STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175169	A. BUILDING _____ B. WING _____	06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COFFEYVILLE REGIONAL MEDICAL CENTER SNF	1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility reported a census of 13 with 17	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 residents selected for sample review. Based on interview and record review, the facility failed to ensure 1 resident (#62) of the 17 reviewed, family member received notification of the resident's change in condition. Findings included: - Resident (#62's) 14 day admission 4/23/14 MDS (Minimum Data Set) assessment, recorded a BIMS (Brief Interview for Mental Status) score of 3 (a score of 0-7 indicated severely impaired cognition), required limited assistance of 1 person with bed mobility, walking in the room/corridor, locomotion on and off the unit; required extensive assistance of 2 staff with transfers, balance not steady when moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfers, functional limitation in ROM (range of motion) on both lower extremities, used a walker, no falls recorded, fell in the last 2-6 months prior to admission, and no fracture related to a fall in the 6 months prior to admission. The 4/25/14 CAA (Care Area Assessment) triggered the following areas: Cognitive Loss/Dementia - Has diagnosis of dementia. Falls - Patient is at risk for falls due to needing help with activities of daily living and patient's medications. The resident's 4/6/14 care plan, had the following interventions: Skilled daily assessment. Fall risk assessment upon admission and as needed. Intervention of 4/7/14 - Physical Therapy inpatient	F 157		

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F 157	Continued From page 2 evaluation. Intervention of 4/7/14 - Rehabilitation - Inpatient patient subject/treatment note. Intervention of 4/7/14 - Occupational Therapy Restorative Evaluation. Intervention of 4/10/14 - Rehabilitation -Restorative Treatment. Intervention of 4/22/14 - Hot pack treatment. Intervention of 4/25/14 - Physical Therapy Restorative Evaluation. Intervention of 5/13/14 - Physical Therapy inpatient evaluation. Intervention of 5/13/14 - Place and keep yellow star on door frame and yellow bracelet on resident. Intervention of 5/13/14 - Bed/chair alarm on at all times. Intervention of 5/13/14 - Keep assistive devices at bedside. Keep assistive devices, such as walker, cane, bedside commode, on exit side of bed. Intervention of 5/13/14 - Use gait belt unless contraindicated. The resident's 4/23/14 care plan had the following interventions: Inpatient evaluation. Place and keep yellow star on the door frame. Place and keep yellow bracelet on resident. Bed/chair alarm on at all times. Keep assistive devices at bedside, such as walker, cane, bedside commode, on exit side of bed. Use gait belt unless contraindicated. The 4/7/14 skilled nurse notes at 10:03 AM recorded a bed alarm used. Nursing notes on 5/8/14 at 1:34 PM, documented the resident's roommate turned the call light on and stated the resident fell. Writer (licensed staff	F 157		

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B) and CNA (certified nurse aide) entered the room and found the resident lying on the floor in front of the roommate's chair. The resident's head was by the roommate's feet, and the resident's feet rested towards the resident's bed. The resident reported no pain. Staff assessed the resident and found no injuries. The resident reported he/she tried to get up to go outside. The resident did not have a chair alarm in place. The clinical record lacked evidence of the doctor or the family/dpoa (durable power of attorney) receiving notification of the fall, at that time.

Nursing notes on 5/9/14 at 8:36 AM, recorded only a bed alarm in place.

Staff recorded on the discharge instruction record of 5/9/14 at 11:13 AM,the resident's activity activity as tolerated and appointment with doctor on 6/2/14 at 10:30 AM.

Nurses notes with a skilled daily assessment of 5/9/14 at 1:03 PM recorded the resident oriented to person; altered perception; gait/transferring weak; mental status - forgets limitations; fall risk score of 19; full range of motion. At 1:04 PM, the resident up in the chair, call bell within reach, bed alarm, no needs voiced and with pleasant behavior.

Review of the resident's ECR lacked documentation of the date and time of the resident's discharge from the skilled nursing unit.

On 5/14/2014 at 12:27 PM, licensed staff K stated the resident fell at home last Friday and fractured the left hip, the staff suspect. The staff had not been able to verify that. The resident did fall last Thursday when he/she was here. However, the resident is going to be transferred to acute care

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today.

A family member reported on 5/15/2014 at 8:46 AM they were not notified of a fall on 5/8/14 while the resident was a patient in the hospital. The family member further reported being the person to be notified in the event of any change in condition, however, did not know about the fall until later, when they took the resident home on 5/9/14. I insisted on a X-ray after realizing after getting the resident home, he/she could not walk. The X-ray (completed on 5/13/14) revealed a fractured hip.

On 5/20/14 at 7:22 AM, licensed staff I stated stated the resident fell on the day shift and now has a fractured hip. We are to call the family with any change in condition and call the doctor.

On 5/21/14 at 11:16 AM, licensed staff L stated when an incident occurs, we complete an incident report, turn the report into QA (Quality Assurance). No one ever questioned me about his fracture or fall.

On 5/21/14 at 2:32 PM, administrative licensed staff A stated the facility practice is to notify the family with each fall. If it is not documented, it was not done.

On 5/21/14 at 3:09 PM, licensed staff B (nurse on duty on 5/8/14 when the resident fell) stated it was lunch time. The resident was up in the chair with the over bed table over his/her lap. The staff heard a loud noise and the call light went off. The roommate had turned on the call light. I checked the resident before staff got him/her up, didn't find any injuries and assisted the resident to bed. I text paged the doctor, and we kept checking on the resident. The on-call doctor came up and

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F 157	Continued From page 5 checked on the resident after the fall. I attempted to call the family member by phone. I know for sure I tried one time, but not sure if I documented it. On 5/22/14 at 8:11 AM, physician D, when asked if staff notified him/her when the resident fell on 5/8/14, he/she stated the staff usually text paged him/her when a resident falls. I don't remember them doing that, and I delete my pages. I saw the resident the next day on Friday, 5/9/14. On 5/23/14 at 12:55 PM, the facility had a fax which read at this time, the facility had not located a policy regarding a timely notification of families. The facility's policy for communications regarding seriously ill patients, reviewed on 3/11/10, recorded a nurse assessing that a change has taken place in a patient's condition will notify the physician. The facility failed to notify the resident's family member and the physician of a fall with a fracture diagnosed 6 days later.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure 1 resident (#63) of 3 reviewed for physical	F 221		

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restraints, remained free of physical restraints imposed for staff convenience and not required to treat the resident for medical symptoms.

Findings included:

- The facility admitted resident #65 on 5/7/14, per the ECR (electronic care record), and discharged to an assisted living facility, on 5/16/14.

The 5/16/14 admission MDS (minimum data set) assessment, included the resident scored 10 on the BIMS (brief interview of mental status) assessment, indicating moderately impaired cognitive status. The resident required extensive assistance of 2 staff for bed mobility and limited assistance of 2 staff for transfers. The assessment further identified the resident used bed side rails daily as a physical restraint.

The 5/19/14 CAAs (care area assessment) identified the resident needed assistance with ADLs (activities of daily living) related to decreased cognition and weakness and used the bed rails for assistance with positioning.

The 5/16/14 care plan lacked instructions to staff for the use of the bed side rails and transfer assistance needs.

On 5/7/14 at 12:43 PM and on 5/12/14 at 8:44 PM, the interdisciplinary nursing notes, identified the use of 4 bed side rails, in the up position, on the resident's bed. On numerous occasions, within the ECR, documentation included the resident had the 4 bed side rails used in the up

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F 221	Continued From page 7 position. A fall risk assessment, dated 5/7/14 at 12:44 PM, identified the resident scored 11, indicating the resident as a high risk for falls. On 5/14/14 at 11:50 AM, the resident sat in the day room, for lunch, with a personal safety alarm noted on the resident's geriatric wheelchair. On 5/14/14 at 3:33 PM, therapy staff H and activity staff E, assisted the resident with ambulation, back to the resident's room, with the use of a rolling walker and with limited assistance noted. On 5/15/14 at 7:30 AM, the resident rested in the bed, with side rails up on both sides of the bed, and at the upper and lower sections of the bed. On 05/14/2014 at 12:00 PM, licensed nursing staff L reported the resident used full side rails on the bed as a physical restraint along with a bed and chair alarm to alert staff when the resident attempted to stand up unassisted. On 5/20/14 at 7:30 AM, direct care staff J reported the resident needed side rails up times 4 whenever the resident rested in the bed, for safety. On 5/21/14 at 11:45 AM, direct care staff C reported the facility used the side rails on the resident's Euro (Trademark)s bed to keep the resident safe and to make the resident feel more secure. Staff C further explained the resident needed limited assistance of staff for transfers, and capable of getting out of bed unassisted, although not safely.	F 221		

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F 221	Continued From page 8 On 5/21/14 at 5:30 PM, administrative nursing staff A, reported the SNF (skilled nursing facility) lacked any physical restraint assessment usage, other than what they assessed in the MDS assessment. The facility policy, dated 5/25/10, for Restraint of Patients, included the resident with the right to be free from restraints, of any kind, not medically necessary or imposed for coercion, discipline, convenience, or retaliation by staff. Additionally, the restraint procedure documented it as preferable to plan staffing to accommodate one on one observation rather than a restraint. The condition of the restrained patient shall be assessed every 15 minutes and documented on an electronic restraint flow sheet. The facility failed to ensure this resident remained free of physical restraints, imposed for purposes of staff convenience, when the staff used the 4 bed side rails to keep the resident in the bed.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		

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F 225	Continued From page 9 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility reported a census of 13 resident's with 13 selected for sample review. Based on observation, interview, and record review, the facility failed to thoroughly investigate and report to the state agency, as required for 1 resident (# 62) of 1 reviewed for accidents who experienced a hip fracture of unknown origin. Findings included: - The facility admitted resident #62 on 4/6/14, per the ECR (electronic care record).	F 225		

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F 225	Continued From page 10 The resident's 14 day admission 4/23/14 MDS (Minimum Data Set) assessment, recorded a BIMS (Brief Interview for Mental Status) score of 3 (a score of 0-7 indicated severely impaired cognition), required limited assistance of 1 person with bed mobility, walking in the room/corridor, locomotion on and off the unit; required extensive assistance of 2 staff with transfers, balance not steady when moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfers, functional limitation in ROM (range of motion) on both lower extremities, used a walker, no falls recorded, fell in the last 2-6 months prior to admission, and no fracture related to a fall in the 6 months prior to admission. The 4/25/14 CAA (Care Area Assessment) with the following areas: Cognitive Loss/Dementia - Has diagnosis of dementia. Falls - Patient is at risk for falls due to needing help with activities of daily living and patient's medications. The resident's 4/6/14 care plan, had the following interventions: Skilled daily assessment. Fall risk assessment upon admission and as needed. Intervention of 4/7/14 - Physical Therapy inpatient evaluation. Intervention of 4/7/14 - Rehabilitation - Inpatient patient subject/treatment note. Intervention of 4/7/14 - Occupational Therapy Restorative Evaluation. Intervention of 4/10/14 - Rehabilitation -Restorative Treatment. Intervention of 4/22/14 - Hot pack treatment.	F 225		

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Intervention of 4/25/14 - Physical Therapy Restorative Evaluation.
Intervention of 5/13/14 - Physical Therapy inpatient evaluation.
Intervention of 5/13/14 - Place and keep yellow star on door frame and yellow bracelet on resident.
Intervention of 5/13/14 - Bed/chair alarm on at all times.
Intervention of 5/13/14 - Keep assistive devices at bedside. Keep assistive devices, such as walker, cane, bedside commode, on exit side of bed.
Intervention of 5/13/14 - Use gait belt unless contraindicated.

The resident's 4/23/14 care plan had the following interventions:
Inpatient evaluation.
Place and keep yellow star on the door frame.
Place and keep yellow bracelet on resident.
Bed/chair alarm on at all times.
Keep assistive devices at bedside, such as walker, cane, bedside commode, on exit side of bed.
Use gait belt unless contraindicated.

Staff recorded the following in the resident's computerized clinical record:
The 4/6/14 ADL (Activity of Daily Living) documentation form at 3:52 PM - the resident used a bed alarm when in bed. Bed mobility with 1 person physical help; transfers 1 person physical assist with a gait belt.

Nursing notes on 5/8/14 at 1:34 PM documented the resident's roommate turned the call light on and stated the resident fell. Writer (licensed staff B) and CNA (certified nurse aide) entered the room and found the resident lying on the floor in front of the roommate's chair. The resident's

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F 225	Continued From page 12	F 225		

head was by the roommate's feet, and the resident's feet rested towards the resident's bed. The resident reported no pain. Staff assessed the resident and found no injuries. The resident reported he/she tried to get up to go outside. The resident did not have a chair alarm in place.

Nursing notes on 5/9/14 at 8:36 AM, recorded only a bed alarm in place.

Staff recorded on the discharge instruction record of 5/9/14 at 11:13 AM, the resident's activity as tolerated and appointment with doctor on 6/2/14 at 10:30 AM.

Nurses notes with a skilled daily assessment of 5/9/14 at 1:03 PM recorded the resident oriented to person; altered perception; gait/transferring weak; mental status - forgets limitations; fall risk score of 19; full range of motion. At 1:04 PM, the resident up in the chair, call bell within reach, bed alarm, no needs voiced and with pleasant behavior.

Review of the resident's ECR lacked documentation of the date and time of the resident's discharge from the skilled nursing unit.

Nursing notes on 5/9/14 at 11:19 PM, recorded at 9:50 PM, (family member) called and reported the resident was not acting appropriately and concerned that staff dismissed the resident before the resident was ready. At 10:10 PM, the doctor returned the call; advised to let the significant other know the resident could be brought back to the skilled nursing unit for readmission and to reinstate the previous orders at this time. At 10:30 PM, the resident readmitted to the facility via EMS. Staff recorded the resident as alert to self, responding

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appropriately to questions by this nurse; physical assessment completed and noted to intervention list at this time. Resident incontinent with brief on. At 11:10 PM, staff recorded the resident currently resting quietly in bed with eyes closed, displayed no signs/symptoms of distress or discomfort at this time, bed alarm set.

Staff recorded in the skilled nursing notes on 5/9/14 at 10:55 PM, the resident as oriented to self, with a bed alarm present and no pain present. Brought back into skilled nursing facility via EMS cart at 10:40 PM and transferred to bed. Vital signs within normal limits. Physical assessment completed at this time and noted to intervention list. Staff changed the resident from sweat pants and shirt to a gown, brief wet from incontinence, and changed. The resident responded appropriately to questions, but unable to state place or time. The resident displayed no signs/symptoms of distress or discomfort at this time.

Staff recorded on the 5/10/14 activities of daily living documentation at 2:53 AM, bed alarm not needed. Transfer support required 2 person physical assist.

Staff recorded in the 5/10/14 nursing notes at 4:40 AM - The resident's (family member) called to check on the resident. Stated surprised by the decline of the resident since Tuesday (5/6) when the significant other talked to the resident on the phone. Staff documented since arrival back on skilled nurse facility at 10:40 PM, the resident moaned as if in pain. The family member stated he/she felt the resident's pain caused by the fact that when leaving the hospital to get into car, he/she was unable to get the resident in the car, the resident had to rest the resident's hip on the

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running board of the car until EMS could help lift the resident in the car. The family member reported the transfer of getting the resident in the car took approximately 15 minutes. The family member stated when the resident arrived home, it took 6 people including EMS to get the resident from the car into the house and into a chair. The family member stated they arrived home at approximately 3:30 PM, and the family member left for work at 5 PM. When the family member arrived home after work, the resident failed to respond and felt extremely warm. Also, this family member stated he/she did not understand why staff discharged the resident since the resident's condition had declined so much. The family member stated the physician had informed he/she the resident had been ambulating in the hallway during the resident's admission on the unit. This nurse explained that while the resident was on the unit, the resident required 1 to 2 staff to get the resident from the bed to the chair, and the resident's activity level had been low.

Staff recorded in the 5/10/14 nursing notes at 5:57 AM, the resident woke to name and light touch at this time. Drinking water and swallows pill without difficulty. When asked if warm enough with just sheet covering stated he/she was just fine. Displayed no signs/symptoms of discomfort, voiced no other needs at this time.

Staff recorded on the 5/10/14 skilled nurse flow sheet at 9:38 AM the use of a bed alarm. The resident denied any needs other than wanting to go to sleep.

Staff recorded on the 5/10/14 skilled daily assessment at 9:41 AM the resident oriented to person, with full range of motion. At 12 noon, the resident sat up in the chair for lunch.

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F 225	Continued From page 15 Activities of daily living documentation, on 5/10/14 at 3:01 PM, revealed the resident required 2 person physical assist for transfers, walking in the room/hall did not occur, and the resident used a bed alarm. Staff recorded in the OT (Occupational Therapy) restorative note of 5/12/14 at 8:43 AM, diagnosis of weakness/falls. Education needs - home exercise program, safety, activities of daily living. No pain present. Left lower extremity range of motion deficit within normal limits. Moderate assistance needed for transfer. Poor rehabilitation potential. The PT (physical therapy) inpatient evaluation on 5/12/14 at 10:55 AM, recorded left and right lower extremity range of motion 50% deficit. Range of motion comments - The resident having a hard time moving lower extremity due to increase in stiffness. Unable to support self in standing. Maximal assistance with transfer support provided. Decreased weight shift left, observed gait dysfunction. Gait comments - the resident scissored. The resident is confused and unable to follow one step command due to confusion. Poor rehabilitation potential. The resident had poor static sitting and standing balance, with complaints of pain. Skilled nurse flow sheet on 5/12/14 at 12:20 PM documented the resident up in the chair for lunch. (family member) at the resident's bedside who stated, "We really should get an x-ray of the left leg and foot." Review of the resident's ECR lacked evidence staff acted upon the resident's significant other's request for an x-ray of the resident's left leg and	F 225		

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F 225	Continued From page 16 foot. Physical therapy notes on 5/12/14 at 3:40 PM documented the resident having difficulty in standing and putting weight on both lower extremities, due to complaints of pain present. The resident unable to rate pain. Resident unable to assist or actively participate with sit to stand needed verbal and tactile cueing in performing standing with 2 person assist, with maximum assistance. Resident not totally putting weight on the left lower extremity. Staff recorded in the skilled daily assessment on 5/13/14 at 8:55 AM, the resident oriented to person, gait/transferring as weak; full range of motion; resident tense. Resident encouraged to take deep breaths and relax. Staff recorded on the skilled daily assessment on 5/13/14 at 9:35 AM, the resident exhibited full range of motion. At 12:33 PM, staff documented the resident sat up in the chair feeding self lunch, with no signs/symptoms of distress. Staff recorded in the inpatient physical therapy treatment note on 5/13/14 at 3:10 PM, the resident having difficulty in standing and putting weight on both lower extremities due to complaints of pain present, unable to rate the pain. The resident unable to assist or actively participate with sit to stand, needed verbal and tactile cueing in performing standing with 2 person assist, maximum assist. The resident not totally putting weight on the left lower extremity, but able to put both feet down on the floor while using the urinal. On 5/14/14 at 10:30 AM, the resident's physician ordered a X-ray of the resident's bilateral hips to rule out a fracture.	F 225		

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The 5/14/14 x-ray of the resident's bilateral hip joints and anterior/posterior pelvis recorded:- Impression - 1. Acute left hip fracture of femur with 2.5 cm (centimeter) overriding. 2. No other abnormality.

On 5/14/14 at 11:15 AM, the physician ordered the resident transferred to acute care for telemetry, with diagnosis of a left hip fracture.

On 5/14/2014 at 12:27 PM, licensed staff K stated the resident fell at home last Friday and fractured the left hip, the staff suspect. The staff had not been able to verify that. The resident did fall last Thursday when he/she was here.

On 5/20/14 at 7:22 AM, licensed staff I stated the resident fell on the day shift and now has a fractured hip. We are to call the family with any change in condition and call the doctor.

On 5/21/14 at 11:05 AM, therapy staff H stated, I told the nurse when we stood the resident up that he/she couldn't stand and I asked if an x-ray had been done. They told me they did not do an x-ray. On 5/13/14 I could see facial expressions that the resident had pain. He/she wouldn't put any weight on his/her left leg.

On 5/21/14 at 11:16 AM, licensed staff L stated normally physical therapy tells us and documents in the notes if the resident is having pain. I worked on 5/12/14, and another nurse worked on 5/13/14. At that time, licensed staff L looked in the computer for the nursing notes on 5/13/14, and reported the nurse on duty on 5/13/14 recorded the resident was unable to rate his/her pain. On 5/9/14, the resident was assisted to a private vehicle by direct care staff C. Licensed

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staff L looked in the ECR and verified he/she could not find any discharge note done on 5/9/14. This licensed staff added the resident was very tense and doesn't bend well. This licensed staff verified the record lacked any discharge notes for 5/14/14 when the resident was transferred to the telemetry unit. This licensed staff stated the physician ordered an x-ray as the (family member) kept saying something was wrong with the resident's left leg. When you were not touching the resident's leg, he/she didn't complain of pain. The resident's mobility had not changed. The resident was a transfer with 1 person assist. The resident had only the one fall on the unit. When an incident occurs, we complete an incident report, turn the report into QA (Quality Assurance). No one ever questioned me about his fracture or fall.

On 5/21/14 at 11:30 AM, direct care staff C stated the resident's (family member) and I took the resident out in a wheelchair. He/she didn't stand very well. He/she was kind of out of it that day. I put the resident in the front seat. He/she was leaning against the console between the front seats, I went and got more help. I did not drop the resident. I went and got the nurse from ER (emergency room). We couldn't get the resident in the car either. Then the ER nurse went and got EMS staff who helped us put the resident into the car. It took 4 EMS staff, me and the ER nurse to get the resident in the car. The resident didn't complain of pain, but kind of moaned. I was not working on the day the resident fell. The resident took 2 staff of maximum assist with transfers. The resident was a little hesitant to put weight on his/her left leg. The resident has dementia.

On 5/21/14 at 2:32 PM, administrative licensed

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staff A stated we should have gotten the x-ray report on the same day the x-ray was done. The physician and I were not aware of the discharge incident in the car. The doctor nor I were aware of the fracture until 5/15/14. X-ray normally calls immediately, but no one said a word. Our fall protocol when a resident falls is for staff to assess the resident, call the doctor, report the vital signs or any apparent injuries, and then staff do according to the physician's orders. Our practice is to notify the family with each fall. If it is not documented, it was not done. There was no follow-up for the resident's family member's request for an x-ray on 5/11/14 at 5:22 PM.

On 5/21/14 at 3:09 PM, licensed staff B (nurse on duty on 5/8/14 when the resident fell) stated it was lunch time. The resident was up in the chair with the over bed table over his/her lap. The staff heard a loud noise and the call light went off. The roommate had turned on the call light. I checked the resident before staff got him/her up, didn't find any injuries and assisted the resident to bed. I text paged the doctor, and we kept checking on the resident. The on-call doctor came up and checked on the resident after the fall. I attempted to call the resident's significant other by phone. I know for sure I tried one time, but not sure if I documented it.

On 5/22/14 at 9:51 AM, administrative nursing staff A stated he/she did not believe the QA (quality assurance) staff reported the fall with a fracture of unknown origin to the State agency.

The facility's policy for reporting of abused, neglected or exploited elderly or other adults who are unable to protect themselves, reviewed on 3/10/13, recorded a report of suspected abuse and/or neglect and/or exploitation should be

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F 225	Continued From page 20 made by the professional who determined that the individual may be a victim of abuse and/or neglect and/or exploitation and should be made as soon as practically possible. The facility failed to thoroughly investigate and report to the state agency this resident's hip fracture of unknown origin.	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: The facility had a census of 13 residents. Based on interview and record review, the facility failed to develop written policies and procedures which prohibited mistreatment, neglect, and abuse of residents. Findings included: - Review of the facility's policy and procedure for reporting of abused, neglected or exploited elderly or other adults who are unable to protect themselves, reviewed on 3/10/13, only addressed the requirement of which staff were required to report abuse, neglect, of exploitation. The policy included the procedure staff needed to follow to report suspected abuse and/or neglect and/or exploitation. Review of the facility's policy failed to include the following required elements:	F 226		

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F 226	Continued From page 21 a) Screening of new employees b) Training of new employees c) Prevention of abuse/neglect/exploitation d) Investigating of suspected abuse/neglect/exploitation e) Protection of the resident during the investigation f) Identification of possible incidents which need investigation. On 6/2/14 at 11:43 AM, licensed administrative staff A stated the facility did conduct back ground checks upon hiring of new employees. However, this staff member verified the facility's policy failed to include the back ground checks of new employees in their policy. In addition, this staff member verified the facility's policy failed to include all the required elements. The facility failed to develop written policies and procedures which prohibited mistreatment, neglect, and abuse of the residents.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview, and record review the facility failed to maintain personal dignity for 1 (#65) of the 17 sampled residents, during meals and ambulation. Additionally, the facility failed to enhance each residents dignity, when the facility failed to provide iced tea in glasses, during dining	F 241		

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observation on 5/14/14, as a reasonable person would expect.

Findings included:

- Observation on 5/14/14 at 11:50 AM, revealed activity staff E, pulled resident # 65 in a geriatric wheel chair, backwards from his/her room to the day room for lunch. The resident remained dressed in a hospital gown, with a white bed blanket placed across the resident's lap. Staff pushed the resident up to the table and placed the lunch tray in front of the resident. Furthermore, during the meal assistance, staff E called the resident "sweetheart," instead of his/her given name.

At 3:33 PM on 5/14/14, therapy staff H and activity staff E assisted the resident with ambulation, from the day room to the resident's room. At that time, the resident's entire back side was open to view, with only a brief under the hospital gown.

On 5/20/14 at 7:25 AM, direct care staff J reported the resident always wore a hospital gown throughout his/her hospital stay.

Direct care staff C, reported on 5/21/14 at 11:45 AM, the residents of the unit usually wore hospital gowns or pajamas throughout the stay in the skilled nursing facility.

Licensed nursing staff B reported on 5/22/14 at 2:10 PM, the patients of the SNF (skilled nursing facility) felt the SNF stay was a continuation of his/her hospital stay, and remained in a hospital gown throughout the day, routinely.

Review of the Guidelines in the skilled nursing

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F 241	Continued From page 23 unit, undated, included the need for families to provide the resident's own personal clothing, for the resident's comfort. The facility failed to ensure the resident appropriately dressed to maintain the resident's dignity, when out of his/her room. Furthermore, the staff failed to maintain the resident ' s dignity with failure to address the resident by the given name. - Observation on 5/14/14 at 12:15 PM identified direct care staff C served lunch trays to the 12 residents receiving a meal on the SNF. At that time staff C used Styrofoam cups to serve iced tea to the residents and used a thermal insulated coffee mug for residents receiving hot coffee. Staff C reported, at that time, the Styrofoam cups kept the tea colder, longer. The facility failed to provide the residents of the SNF a regular glass for drinking iced tea, instead serving the iced tea in a Styrofoam cup, as a reasonable person would expect their food served in non-disposable dishware.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview, and record review, the	F 248		

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facility failed to provide an ongoing program of activities for the residents of the SNF (skilled nursing facility), including 3 (#68, #9, and #63) of the 3 residents reviewed for activities.

Findings included:

- The facility admitted resident #9 on 4/24/14 per the ECR (electronic care record) and discharged the resident back to home on 5/14/14.

The 5/11/14 admission MDS (minimum data set) assessment identified the resident with cognition intact with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident ' s activity preference included; it was very important to do things with groups of people and to participate in his/her favorite activity. The resident required limited assistance of 1 staff for mobility and transfers.

The 5/11/14 CAA (care area assessment), included the resident needed assistance with ADLs (activities of daily living) due to weakness of the resident ' s bilateral lower extremities.

The 4/24/14 care plan, lacked instruction to the staff in the resident's activity preferences.

On 4/25/14 at 1345 (1:45 PM) and again on 5/9/14 at 17:07 (5:07 PM), activity flow sheets identified the staff provided the resident a newspaper to read.

On 4/25/14 at 1347 (1:47 PM), an interest survey identified the resident reported keeping up with news as very important, along with doing his/her favorite activities (not identified in the resident's plan of care), going outside for fresh air, staying up late, napping regularly, and staying busy with

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F 248	Continued From page 25 hobbies (again not identified in the plan of care). On 5/7/14 at 1622 (2:22 PM), activity interdepartmental notes included the resident attended a chaplain visit in the day room, and staff propelled the resident back to his/her room. The resident appeared attentive and talkative with others. Review of the Activity Calendar, dated April and May, 2014, identified the staff planned the same activity each week, including the following: Monday--Manicure/lotion Tuesday--Newspaper Wednesday--Chaplain Devotion Thursday--Newspaper Friday--Bingo or choice Saturday--Board games/cards, puzzles Sunday--TV Mass Observations on 5/14/2014 and 5/15/2014, revealed the activity director on the unit for a portion of each day, and a chaplain visited on 5/15/15. On 5/20/14, 5/21/14, and 5/22/14, observations lacked identification of any staff led activity. A chaplain visited on 5/21/14, in the day room, for approximately 30 minutes. However, no residents attended the devotions in the day room and the chaplain exited the facility without seeing any of the residents. On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted in the care plan or anywhere the staff would be able to look and determine what the resident's wished to participate in or had interest in doing. Staff B reported the patients basically	F 248		

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COFFEYVILLE REGIONAL MEDICAL CENTER SNF	1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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see the SNF (skilled nursing facility) stay as a continuation of his/her hospitalization and typically spend their days working with therapy, watching television and do receive newspapers several times a week. Staff B further agreed the activity program frequently lacked residents ' attendance.

On 5/14/2014 at 11:46 AM, the resident reported they attended church once or twice and participated in a group lunch. The resident reported otherwise no knowledge of any planned activities or activity program for the SNF. When asked if the staff provided activity items such as reading materials, cards or games, the resident reported the staff failed to offer any of those items.

The facility policy for Skilled Nursing Unit, Activities, dated 3/11/10, instructed the Activities Director to have available activities for all levels of care. Activities should include devotions with chaplains and two group activities.

The facility failed to provide an ongoing activity program to meet the interests and physical, mental and psychosocial well-being for this resident.

- The facility admitted resident #63 on 5/1/14 per the ECR (electric care record) and remained in the SNF (skilled nursing facility), throughout the survey.

The 5/15/14 admission MDS (minimum data set) assessment identified intact cognition with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident required limited assistance of 1 staff for dressing

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and independent for all other ADLs (activities of daily living). The resident identified in the assessment it was very important to choose clothing to wear daily, taking care of his/her self, and having family involved in care. Related to activities, the resident reported as somewhat important to have newspapers, books and group activity.

The 5/1/14 initial care plan, instructed staff to complete the activity flow sheet, activity interest survey, and an activity assessment. However the care plan lacked identification of any resident desired activities. The facility lacked a comprehensive activity care plan, at the time.

An activity flow sheet, dated 5/5/14, identified the resident's activities included television, reality orientation, reading material, sensory stimulation, picture books, creative expression, discussion, and conversation.

On 5/14/14 at 1636 (4:36 PM), interdisciplinary notes, indicated the resident declined devotions this date due to increased pain and not wanting to leave his/her room.

On 5/16/14 at 1438 (2:38 PM), interdisciplinary notes, indicated the activity staff offered and provided a few magazines and several puzzles to work on this weekend. The documentation indicated the resident as thankful for the items.

Review of the Activity Calendar, dated April and May, 2014, identified the staff planned the same activity each week, including the following:

Monday--Manicure/lotion
Tuesday--Newspaper
Wednesday--Chaplain Devotion

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F 248	Continued From page 28 Thursday--Newspaper Friday--Bingo or choice Saturday--Board games/cards, puzzles Sunday--TV Mass Observations on 5/14/2014 and 5/15/2014, identified the activity director on the unit for a portion of each day, and a chaplain visited on the afternoon of 5/14/14. On 5/20/14, 5/21/14, and 5/22/14, observations lacked identification of any staff led activity provided. A chaplain visited on the 5/21/14 for 30 minutes; however, no residents attended the devotions. On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted in the care plan or anywhere the staff would be able to look and determine what the residents wished to participate in or had interest in doing. Staff B reported the residents basically see the SNF stay as a continuation of his/her hospitalization and typically spend their days working with therapy, watching television. The residents do receive newspapers several times a week. Staff B further agreed the activity program frequently lacked residents ' attendance. On 5/14/14 at 4:15 PM, the resident visited with a guest. On 05/14/2014 at 10:36 AM, the resident reported not feeling up to participating in outside of their room activities yet. However the resident stated, they did bring me a newspaper to read, but failed to offer any other activity type items. On 5/20/14 at 9:53 AM, the resident rested in bed, while speaking on his/her cellular phone.	F 248		

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F 248	Continued From page 29 On 5/22/14 at 4:24 PM, licensed nursing staff L reported the resident, upon admission, asked that his/her room be posted for no visitors. However, now the resident seemed to be doing better and getting out of his/her room for therapy at least. The staff lacked knowledge of the resident's activity interests. The facility policy for Skilled Nursing Unit, Activities, dated 3/11/10, instructed the Activities Director to have available activities for all levels of care and to include devotions with chaplains and two group activities. The facility failed to provide an ongoing activity program to meet the interests and physical, mental and psychosocial well-being for this resident. - The facility admitted resident #68 on 5/9/14, per the ECR (electronic care record) and discharged the resident to home on 5/19/14. The admission 5/19/14 MDS (minimum data set) assessment, identified the resident ' s cognition intact with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident identified as independent with ADL's (activities of daily living) and the resident reported as very important to do things with groups of people and participate in their favorite activity. The 5/10/14 initial care plan, instructed staff the resident needed an activity assessment and an activity flow sheet. However, the care plan lacked instructions to staff as to what activities the resident liked to do.	F 248		

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F 248	Continued From page 30 A 5/9/14 activity assessment, identified the resident liked to stay up past 9 PM, napped regularly, kept busy with hobbies, reading, and spent most of his/her time watching TV. A 5/12/14, activity flow sheet, identified activities included television, reality orientation, reading material, scent sensory stimulation, picture book reality orientation, tactile sensory stimulation, creative expression, sound sensory stimulation, discussion/conversation, visual sensory stimulation, and family visits. The 5/12/14 interest survey, identified music somewhat important to the resident, very important to have reading materials, keeping up with the news, doing things with groups of people, doing his/her favorite activities, going outside for fresh air, and participating in religious services. On 5/14/14 at 1644 (4:44 PM), interdisciplinary notes documented the staff asked the resident about eating lunch in the day room with some of the other residents and the resident declined. On 5/16/14 at 1440 (2:40 PM), interdisciplinary notes documented the patient was asked if he/she needed anything to pass the time over the weekend. The patient declined and thanked the staff for the offer, stating, they brought some things from home to work on. Review of the Activity Calendar, dated April and May, 2014, identified the staff planned the same activity each week, including the following: Monday--Manicure/lotion Tuesday--Newspaper Wednesday--Chaplain Devotion Thursday--Newspaper	F 248		

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F 248	Continued From page 31 Friday--Bingo or choice Saturday--Board games/cards, puzzles Sunday--TV Mass Observation on 5/14/2014 and 5/15/2014 identified the activity director on the unit for a portion of each day, and a chaplain visited on the afternoon of 5/14/14. On 5/20/14, 5/21/14, and 5/22/14, observations lacked identification of any staff led activity. A chaplain visited on 5/14/14 for 30 minutes. However, no residents attended the devotions. On 5/15/14 at 8:12 AM, interview with the resident regarding activities offered by the staff, identified the resident had not felt like attending much activities, and further indicated the staff had never offered the resident any items, such as books or magazines, to do on their own. On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted to the care plan or anywhere the staff would be able to look and determine what the residents wished to participate in or had interest in doing. Staff B reported the patients basically see the SNF (skilled nursing facility) stay as a continuation of his/her hospitalization and typically spend their days working with therapy, watching television and do receive newspapers several times a week. Staff B further agreed the activity program frequently lacked resident attendance. The facility policy for Skilled Nursing Unit, Activities, dated 3/11/10, instructed the Activities Director to have available activities for all levels of care to include devotions with chaplains and two group activities.	F 248		

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F 248	Continued From page 32 The facility failed to provide an ongoing activity program to meet the interests and physical, mental and psychosocial well-being for this resident.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on interview and record review the facility failed to	F 278		

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ensure accuracy of assessments for 1 resident (# 47), of the 17 residents reviewed.

Findings included:

- The facility admitted resident #47 on 2/1/14, per the ECR (electronic care record) with diagnoses of lung cancer (malignant neoplasm), pleural effusion (abnormal accumulation of fluid in the lungs), and secondary malignancy - liver. The resident died in the facility on 2/23/14.

The resident's admission MDS (Minimum Data Set) assessment, dated 2/7/14 recorded the resident's BIMS (brief interview for mental status) not assessed and lacked information on the resident's cognition. Additionally, the assessment identified cancer as a diagnosis, but lacked identification of the resident's prognosis, of less than 6 months to live.

The 2/1/14 care plan lacked instructions in the resident's care needs related to end of life.

A 2/13/14 at 9:29 AM oncologist (cancer physician) note identified the resident with lung cancer and brain metastases (spreading of cancer).

A 2/23/14 discharge summary identified the resident expired with a final diagnoses of metastatic right lung, small cell carcinoma (cancer) with a large pleural effusion. The resident admitted to acute care on 1/29/14 with significant dehydration, weight loss, and recurrence of the cancer. The resident was stabilized and transferred to the skilled nursing care, on 2/1/14, for pain management. Most of the medications were discontinued as the patient was getting quite terminally ill.

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F 278	Continued From page 34 On 5/21/14 at 11:42 AM, direct care staff C stated the resident as mostly independent with the spouse assisting the resident a lot. On 5/22/14 at 2:22 PM, licensed nursing staff B, responsible for the MDS assessments, stated the staff should have marked the MDS for a life expectancy of less than 6 months. The facility failed to ensure the resident's assessments as accurate to instruct the staff in the resident care needs for the end of life expectancy.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by:	F 279		

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The facility had a census of 12 residents, with 17 residents reviewed. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 5 of the 17 residents reviewed, which included residents (#62) for constipation, (#34) for fluid restriction, (# 9 and #63) for activities, (#9) for nutrition and (#39) for rehabilitation/mobility needs.

Findings include:

- The facility admitted resident #62 on 4/6/14, per the ECR (electronic care record).

The resident's 14 day admission 4/23/14 MDS (Minimum Data Set), recorded a BIMS (brief interview for mental status) score of 3, indicating the resident severely impaired of cognitive status. The resident required limited assistance of 1 person with bed mobility and required extensive assistance of 2 staff with transfers and toileting.

The 4/6/14 care plan, lacked instructions related to the resident bowel habits/needs.

Review of the resident's physician orders included the following medications related to bowel function.

On 4/6/14, Colace, 100 mg (milligrams), BID (twice daily) for constipation.
On 4/23/14, Fleets enema once for constipation.

BM (bowel movement) monitoring lacked identification of a BM or the facility providing any additional interventions to facilitate a BM, from 4/24/14 until 5/1/14, for 7 days.

Direct care staff C reported on 5/21/14 at 11:42 AM, the direct care staff (or nurses, if present)

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document BM's into the ECR. Then, daily the licensed nurses are checking to ensure all residents are having routine BM's. Sometimes the CNAs (certified nurse aides) also look into the computer and if seeing a resident did not have a BM for a few days, they would tell the nurse.

On 5/22/14 at 5 PM, licensed nursing staff B stated, the nurses or the aides check the BMs and if no BM for several days, then the nurse calls the physician.

On 5/22/14 at 5:03 PM, administrative nursing staff A stated, the unit's BM policy was if no BMs in 3 days, assess and notify the doctor.

On 5/22/14 at 5:30 PM, licensed nursing staff B verified the resident did not have any BM's from 4/24/14 until 5/1/14, and that the facility failed to provide medications/interventions to assist the resident with having a BM, and failed to notify the physician, as planned.

The facility, 12/8/11, Bowel movement monitoring policy, instructed staff that residents who do not have a bowel movement after three consecutive days, will be referred to the licensed nursing staff and the physician will be notified for orders or PRN medications will be given.

The facility's policy for nursing assessment of patients, revised on 1/13/04, recorded the resident's plan of care is developed based on identified nursing diagnoses and/or resident care needs, patient care standards, and is consistent with the therapies of other disciplines. The plan of care is established by the RN.

The facility failed to develop a comprehensive care plan which addressed this resident's care

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F 279	Continued From page 37 concern of constipation. - The facility admitted resident #34 on 1/14/14, per the ECR (electronic care record), with diagnoses of renal insufficiency, Stage IV (the inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes and likely to require dialysis or transplant at stage IV) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid). The physician ordered a low sodium diet with a 1 liter of fluid restriction per day, on 1/14/14. The resident's 1/21/14 admission MDS (Minimum Data Set) assessment recorded a BIMS (brief interview for mental status) score of 12, indicating moderately impaired cognition, independent with set-up help for eating, and required limited assistance of 1 staff with bed mobility, and 2 staff with transfers. The assessment lacked identification of any nutritional approaches. The resident's 1/14/14 care plan identified the following interventions: MDS dietary assessment. Dietician assessment. Weekly weights. Maintain fluid restrictions. However, the resident's care plan lacked specific instructions to staff including how to monitor the resident's actual fluid intake. Review of nursing documentation included the following: Skilled daily assessment, dated 1/21/14 at 8:21 AM, identified bilateral lower extremity edema,	F 279		

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F 279	Continued From page 38 with diminished lung sounds. Skilled daily assessment, dated, 1/23/14 at 8:30 AM, identified bilateral lower extremity edema, and lung sounds coarse throughout. Skilled daily assessment, dated 1/30/14 at 11:30 AM, identified a pulse rate of 125, lung sounds with crackles and coughing repeatedly, O2 (oxygen) on and weak. Skilled nursing flow sheet, dated 2/1/14 at 9:08 AM, identified the staff pulled the resident up and repositioned the patient, in bed, at this time. The resident is currently receiving comfort care with family at bedside and receiving O2 at 5L (liters). Staff provided oral care at this time. The resident was unable to take medications at this time. A 1/24/14 RD (registered dietician) assessment, identified the resident's fluid intake order is followed except on 1/21. A 1 L fluid restriction, with dietary providing only 500 ml of the resident's beverage daily. Review of I&O (intake and output) records included the following: 1/15/14 - oral intake - 720 ml. 1/18/14 - oral intake 720 ml. 1/19/14 - oral intake 910 ml. 1/20/14 - oral intake 920 ml. 1/21/14 - oral intake 1960 ml. 1/25/14 - oral intake 830 ml. 1/27/14 - oral intake 640 ml. 1/28/14 - oral intake 710 ml. Direct care staff C, on 5/21/14 at 11:42 AM, stated the resident didn't eat well, was weak and difficult to get up at times.	F 279		

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Dietary staff N, on 5/22/14 at 12:09 AM, reported he/she assessed the resident within 72 hours of admission. Staff N further noted that any resident on a fluid restriction is given 1/2 the fluid allotment from dietary and the other 1/2 are to be provided by nursing.

On 5/22/14 at 1:45 PM, licensed nursing staff B reported the resident's amount of fluid restriction failed to be noted to the resident's care plan and that staff document in the I&O record of the computer for fluid intake/output. At 2:04 PM, staff B further reported the resident received more intake than ordered. Staff B noted the direct care staff is made aware of the resident's fluid restrictions by shift to shift report.

Direct care staff S reported on 5/22/14 at 2:41 PM, the direct care staff is made aware of fluid restrictions in report and from the resident's order sheet. Staff S reported the direct care staff input the resident's fluid intake at meal times and other water intake into the computer. Staff S further reported the dietary staff does not send fluids up on the resident trays and the nursing staff provide all of the resident's fluids.

The facility policy for I & O, dated 7/30/07, instructed staff in measuring fluid intake and output as very important for all patients who are hospitalized with illness. A request for a policy related to fluid restrictions, was not provided.

The facility's policy for nursing assessment of patients, revised on 1/13/04, recorded the resident's plan of care is developed based on identified nursing diagnoses and/or resident care needs, patient care standards, and is consistent with the therapies of other disciplines. The plan of care is established by the RN.

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COFFEYVILLE REGIONAL MEDICAL CENTER SNF	1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 40 The facility failed to develop a comprehensive care plan for this resident which directed staff to accurately provide the limited fluids as ordered by the resident's physician. - The facility admitted resident #9 on 4/24/14 per the ECR (electronic care record) and discharged the resident back to home on 5/14/14. A 5/11/14 admission MDS (minimum data set) assessment identified the resident with cognition intact with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident's activity preference included; it was very important to do things with groups of people and to participate in his/her favorite activity. The assessment additionally identified the resident required limited assistance of 1 staff for mobility and transfers, and identified the resident independent with eating after setup help provided by staff. The 5/11/14 CAA (care area assessment), included the resident needed assistance with ADLs (activities of daily living) due to weakness of the resident's bilateral lower extremities, identified the resident's BMI (body mass index) indicated the resident overweight for his/her height and on a diabetic diet. The 4/24/14 care plan, instructed staff the resident needed a dietary assessment, a dietician assessment, weekly weights, and meal intake assessment. However, the care plan lacked specific instructions related to the resident's diet orders, of an 1800 ADA (American Diabetic Association), lactose intolerant, with small amounts of dairy acceptable, enjoyed soy milk, as	F 279		

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indicated in the dietician assessment, dated 4/24/14, as well as lacking instruction to the staff in the resident's activity preferences.

On 5/14/2014 at 11:46 AM, the resident reported they attended church once or twice and participated in a group lunch. The resident reported otherwise no knowledge of any planned activities or activity program for the SNF. When asked if the staff provided activity items such as reading materials, cards or games, the resident reported the staff failed to offer any of those items.

On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted in the care plan or anywhere the staff would be able to look and determine what the resident's wished to participate in or had interest in doing. Staff B reported the residents basically see the SNF (skilled nursing facility) stay as a continuation of his/her hospitalization and typically spend their days working with therapy, watching television and do receive newspapers several times a week. Staff B further agreed the activity program frequently lacked residents' attendance.

The facility failed to develop a plan of care to instruct staff in the resident's activity preferences and nutritional needs.

- The facility admitted resident #63 on 5/1/14 per the ECR (electric care record).

The 5/15/14 admission MDS (minimum data set) assessment identified intact cognition with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident required limited assistance of 1 staff for dressing

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F 279	Continued From page 42	F 279		

and independent for all other ADLs (activities of daily living). The resident identified in the assessment it was very important to choose clothing to wear daily, taking care of his/her self, and having family involved in care. Related to activities, the resident reported as somewhat important to have newspapers, books and group activity.

The 5/1/14 initial care plan, instructed staff to complete the activity flow sheet, activity interest survey, and an activity assessment. However, the care plan lacked identification of any resident desired activities. The facility lacked a comprehensive activity care plan, at the time.

On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted in the care plan or anywhere the staff would be able to look and determine what the residents wished to participate in or had interest in doing. Staff B reported the residents basically see the SNF stay as a continuation of his/her hospitalization and typically spend their days working with therapy, watching television. The residents do receive newspapers several times a week. Staff B further agreed the activity program frequently lacked residents' attendance.

The facility failed to develop and implement a comprehensive plan of care for the resident to instruct staff in a consistent and comprehensive provision of care to the resident for activities.

- The facility admitted resident # 39 on 2/4/14, per the ECR (electronic care record), and discharged to home on 3/19/14, following rehabilitation.

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F 279	Continued From page 43 The resident's 2/10/14 admission MDS (minimum data set) assessment, identified the resident scored 15/15 on the BIMS (brief interview for mental status) assessment, needed limited assistance of 1-2 staff for walking and toileting. The assessment further identified the resident with a hip fracture. The 2/4//14 CAAS (care area assessment summary) for Rehabilitation identified the resident with a potential to increase independence in ADL's (activities of daily living) and required encouragement to become more independent. The resident's 3/19/14 care plan identified the resident required PT/OT (physical and occupational therapy) rehabilitation treatment. However, the care plan lacked any other instructions to the staff related to the resident's mobility/care needs or the amount of assistance required. Licensed nursing staff B, reported on 5/22/14 at 1:50 PM, the current care plans in the facility computer system do not identify resident care needs and needed improvement. The facility failed to develop and implement a comprehensive plan of care for this resident, who required rehabilitation to return home, to instruct staff in the provision of consistent, quality care, to meet the resident's needs.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 44 and plan of care. This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview, and record review the facility failed to ensure 1 resident (# 34) of the 17 reviewed, received appropriate, physician ordered fluid restrictions. Findings included: - The facility admitted resident #34 on 1/14/14, per the ECR (electronic care record), with diagnoses of renal insufficiency, Stage IV (the inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes and likely to require dialysis or transplant at stage IV) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid). The physician ordered a low sodium diet with a 1 liter of fluid restriction per day, on 1/14/14. The resident's 1/21/14 admission MDS (Minimum Data Set) assessment recorded a BIMS (brief interview for mental status) score of 12, indicating moderately impaired cognition, independent with set-up help for eating, and required limited assistance of 1 staff with bed mobility, and 2 staff with transfers. The assessment lacked identification of any nutritional approaches. The resident's 1/14/14 care plan identified the following interventions: MDS dietary assessment. Dietician assessment.	F 309		

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F 309	Continued From page 45 Weekly weights. Maintain fluid restrictions. Review of nursing documentation included the following: Skilled daily assessment, dated 1/21/14 at 8:21 AM, identified bilateral lower extremity edema, with diminished lung sounds. Skilled daily assessment, dated, 1/23/14 at 8:30 AM, identified bilateral lower extremity edema, and lung sounds coarse throughout. Skilled daily assessment, dated 1/30/14 at 11:30 AM, identified a pulse rate of 125, lung sounds with crackles and coughing repeatedly, O2 (oxygen) on and weak. Skilled nursing flow sheet, dated 2/1/14 at 9:08 AM, identified the staff pulled the resident up and repositioned the patient, in bed, at this time. The resident is currently receiving comfort care with family at bedside and receiving O2 at 5L (liters). Staff provided oral care at this time. The resident was unable to take medications at this time. A 1/24/14 RD (registered dietician) assessment, identified the resident's fluid intake order is followed except on 1/21. A 1 L fluid restriction, with dietary providing only 500 ml of the resident ' s beverage daily. Review of I&O (intake and output) records included the following: 1/15/14 - oral intake - 720 ml. 1/18/14 - oral intake 720 ml. 1/19/14 - oral intake 910 ml. 1/20/14 - oral intake 920 ml. 1/21/14 - oral intake 1960 ml.	F 309		

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F 309	Continued From page 46 1/25/14 - oral intake 830 ml. 1/27/14 - oral intake 640 ml. 1/28/14 - oral intake 710 ml. Direct care staff C, on 5/21/14 at 11:42 AM, stated the resident didn't eat well, was weak and difficult to get up at times. Dietary staff N, on 5/22/14 at 12:09 AM, reported he/she assessed the resident within 72 hours of admission. Staff N further noted that any resident on a fluid restriction is given 1/2 the fluid allotment from dietary and the other 1/2 are to be provided by nursing. On 5/22/14 at 1:45 PM, licensed nursing staff B reported the resident's amount of fluid restriction failed to be noted to the resident's care plan and that staff document in the I&O record of the computer for fluid intake/output. At 2:04 PM, staff B further reported the resident received more intake than ordered. Staff B noted the direct care staff is made aware of the resident's fluid restrictions by shift to shift report. Direct care staff S reported on 5/22/14 at 2:41 PM, the direct care staff is made aware of fluid restrictions in report and from the resident's order sheet. Staff S reported the direct care staff input the resident's fluid intake at meal times and other water intake into the computer. Staff S further reported the dietary staff does not send fluids up on the resident trays and the nursing staff provide all of the resident ' s fluids. The facility policy for I & O, dated 7/30/07, instructed staff in measuring fluid intake and output as very important for all patients who are hospitalized with illness. A request for a policy related to fluid restrictions, was not provided.	F 309		

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F 309	Continued From page 47 The facility failed to ensure this resident, on a fluid restriction diet received only the physician ordered milliliter of fluid per day when the facility failed to have a standardized method for all staff to follow when implementation of fluid restriction as ordered by the physician.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review included 3 reviewed for ADL (activity of daily living). Based on observation, interview, and record review, the facility failed to provide necessary ADL assistance, for the 3 residents reviewed, including (# 59 and #66) for nail care and (#65) for dressing. Findings included: Findings included: - The facility admitted resident #59 on 5/13/14, per the ECR (electronic care record). The resident's 5/18/14 admission MDS (Minimum Data Set) assessment recorded a BIMS (brief interview for mental status) score of 15/15, indicating intact cognition. The resident required total dependence of 2 staff with bed mobility, transfers and walking. The resident further	F 312		

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F 312	Continued From page 48 required extensive assistance of 1 staff with dressing and personal hygiene. The 5/18/14 CAAS (care area assessment summary) triggered ADLs (activity of daily living) due to total dependence with ADLs related to weakness and a history of CVA (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The resident's initial 5/13/14 care plan included the following interventions: Shower/bathe patient twice a week. ADL Documentation on 6 A and 6 P. On 5/14/2014 at 3:45 PM, observation identified the resident with a black substance under the resident's fingernails. On 5/15/14 at 3 PM, the resident stated he/she had a shower today, but the staff did not clean or trim his/her fingernails. Direct care staff J reported on 5/20/14 at 7:15 AM, the aides provide showers to residents wanting them on the night shift, and if the nails are dirty, the CNA's (certified nurse aides) try to clean them. However, the staff reported the facility lacked any schedule for the residents nail care. Sometimes the activity staff do nail care on the day shift when the activity director completes nail care, as part of the activity program. On 5/20/14 at 8 AM, direct care staff C, stated every 3 days residents get a shower, their hair washed, shaved, and other personal hygiene, however, the activity staff does the residents ' nail care. On 5/21/14 at 11:42 AM, direct care staff C further identified the aides lacked access	F 312		

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F 312	Continued From page 49 to items for nail care, and again, stated, the activity staff do the nail care for the patients. On 5/22/14 at 2:30 PM, licensed nursing staff B stated the aides should be looking at nails during cares. The facility failed to ensure the resident maintained good hygiene when staff failed to clean the resident's soiled nails, as needed. - The facility admitted resident #66 on 5/13/14, per the ECR (electronic care record). The resident's 5 day MDS (Minimum Data Set), dated 5/20/14, was not completed in the computer. The 5/13/14 care plan recorded the following interventions: Shave patient three times a week & prn (as needed). Shower/bathe patient twice a week. ADL (activity of daily living) documentation 6 AM and 6 PM. Review of ADL documentation on 5/13/14 at 8:09 PM, recorded personal hygiene per 1 person physical assist. On 5/14/2014 at 11:30 AM, observation identified the resident with dark discoloration under the resident ' s fingernails. On 5/20/14 at 9:20 AM, observation revealed the resident in bed, now with fingernails neatly trimmed and clean. The resident stated I trimmed my nails myself yesterday. I don't remember if anyone has offered to trim my nails	F 312		

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for me or not.

On 5/20/14 at 7:15 AM, direct care staff J stated the resident is alert and oriented, and would have nail care provided by family or on day shift. The staff further explained, residents requesting a bath/shower on the evening or night shift would be accommodated, upon request, and the staff would clean their nails as needed.

On 5/21/14 at 11:42 AM, direct care staff C stated regarding nail care, that the day staff activity person completed nail care as part of the activity program. The staff further explained the aides don't provide nail care during showers, due to a lack of nail care items.

Licensed nursing staff I stated on 5/20/14 at 7:22 AM, the activity staff completed the residents nail care.

On 5/22/14 at 2:30 PM, licensed nursing staff B stated the aides should be looking at nails during cares.

The facility failed to ensure the resident received appropriate nail care, as needed.

- Per the ECR (electronic clinical record) the facility admitted resident #65 on 5/7/14 and discharged the resident on 5/16/14.

A 5/16/14 admission MDS (minimum data set) assessment, included the resident scored 10/15 on the BIMS (brief interview for mental status) assessment, indicating the resident moderately impaired of cognition. The assessment additionally identified the resident required extensive assistance of 2 staff for personal

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F 312	Continued From page 51 hygiene/dressing. The 5/19/14 CAA (care area assessment) for ADLs (activities for daily living) identified the resident needed assistance with ADLs due to decreased cognition and weakness, and used bed side rails, times 4, for assistance with positioning. The resident's 5/16/14 care plan, instructed staff the resident needed shaving 3 times a week and prn (as needed), showered/bathed twice a week. It lacked instructions to the staff for dressing the resident. On 5/14/14 at 11:50 AM, observation identified activity staff E, pulled the resident backwards in his/her geriatric wheelchair, from the resident's room to the day room. The staff then pushed the chair up to the dining room table for lunch. Observation further identified the resident dressed in a hospital gown, without the ties in place properly, exposing the residents bare skin under the gown. On 5/14/14 at 3:33 PM, activity staff E and therapy staff H, assisted the resident with ambulation back to his/her room. Upon standing the resident's hospital gown gapped open in the back, revealing the resident's bare skin, with only incontinence brief and socks on his/her body, under the gown. On 5/20/14 at 7:25 AM, direct care staff J reported the resident always wore a hospital gown throughout his/her hospital stay. Direct care staff C, reported on 5/21/14 at 11:45 AM, the residents of the unit usually wore hospital gowns or pajamas throughout the stay in the	F 312		

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F 312	Continued From page 52 skilled nursing facility. Licensed nursing staff B reported on 5/22/14 at 2:10 PM, the patients of the SNF (skilled nursing facility) stay a continuation of his/her hospital stay, and remains in a hospital gown throughout the day. Review of the Guidelines in skilled nursing unit, undated, included the need for families to provide the resident's own personal clothing, for the resident's comfort. The facility failed to provide the dependent resident with assistance to dress appropriately for the day time, and out of the room during meals/an activity.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 13 residents, with 17 residents reviewed. Based on observation, interview, and record review, the facility failed to provide interventions as planned to prevent accidents for the only resident (#62) who experienced a hip fracture, reviewed for accidents, and failed to ensure the residents' environment remained free from accident hazards in the rehabilitation room and the day room.	F 323		

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F 323	Continued From page 53	F 323		

Findings included:

- The facility admitted resident #62 on 4/6/14, per the ECR (electronic care record), with diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), and hypertension (elevation of blood pressure).

The resident's 14 day admission 4/23/14 MDS (Minimum Data Set) assessment, recorded a BIMS (Brief Interview for Mental Status) score of 3 (a score of 0-7 indicated severely impaired cognition), required limited assistance of 1 person with bed mobility, walking in the room/corridor, locomotion on and off the unit; required extensive assistance of 2 staff with transfers, balance not steady when moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfers, functional limitation in ROM (range of motion) on both lower extremities, used a walker, no falls recorded, fell in the last 2-6 months prior to admission, and no fracture related to a fall in the 6 months prior to admission.

The 4/25/14 CAA (Care Area Assessment) for falls recorded the resident was at risk for falls due to needing help with activities of daily living and resident ' s medications.

The resident's 4/6/14 care plan, had the following interventions:
Skilled daily assessment.
Fall risk assessment upon admission and as needed.
Interventions of 4/7/14 - Physical Therapy inpatient evaluation.

Rehabilitation - Inpatient

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F 323	Continued From page 54 patient subject/treatment note. Occupational Therapy Restorative Evaluation. Intervention of 4/10/14 - Rehabilitation -Restorative Treatment. Intervention of 4/22/14 - Hot pack treatment. Intervention of 4/23/14 - Bed/chair alarm on at all times Intervention of 4/25/14 - Physical Therapy Restorative Evaluation. Interventions of 5/13/14 - Physical Therapy inpatient evaluation. Place and keep yellow star on door frame and yellow bracelet on resident. Bed/chair alarm on at all times. (In place since 4/23/14). Keep assistive devices at bedside. Keep assistive devices, such as walker, cane, bedside commode, on exit side of bed, and use gait belt unless contraindicated. Staff recorded the following fall risk assessments: On 4/6/14 = 14 - high risk - no falls in 3 months; gait weak; forgets limitations. On 5/10/14 = 19 - high risk - no falls in 3 months; gait weak; forgets limitations. On 5/13/14 = 22 - high risk - no falls in 3 months; gait weak; forgets limitations. Staff recorded the following in the resident's computerized clinical record: The 4/6/14 ADL (Activity of Daily Living) documentation form at 3:52 PM, recorded the resident used a bed alarm when in bed. The resident required 1 person physical help with bed mobility and transfers, with a gait belt. The 4/7/14 skilled nurse notes at 10:03 AM recorded the resident had a bed alarm.	F 323		

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F 323	Continued From page 55 Skilled nursing notes on 5/7/14 at 8 AM recorded the use of a bed alarm. At 12 noon, the nurses' notes recorded the resident continued with the bed alarm. Nursing notes on 5/8/14 at 1:34 PM documented the resident's roommate turned the call light on and stated the resident fell. Writer (licensed staff B) and CNA (certified nurse aide) entered the room and found the resident lying on the floor in front of the roommate's chair. The resident's head was by the roommate's feet, and the resident's feet rested towards the resident's bed. The resident reported no pain. Staff assessed the resident, found no injuries, and assisted the resident to bed. The resident reported he/she tried to get up to go outside. The resident did not have a chair alarm in place as care planned. Nursing notes on 5/9/14 at 8:36 AM, recorded only a bed alarm in place. Nurses notes with a skilled daily assessment of 5/9/14 at 1:03 PM recorded the resident was oriented to person; had altered perception; weak with gait/transferring; mental status - forgets limitations; fall risk score of 19; full range of motion. At 1:04 PM, the resident was up in the chair, call bell within reach, and a bed alarm in place. Review of the resident's ECR lacked documentation of the date and time of the resident's discharge from the skilled nursing unit. Nursing notes on 5/9/14 at 11:19 PM, recorded at 9:50 PM, (family member R) called from home and reported the resident was not acting appropriately and concerned that staff dismissed	F 323		

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the resident before the resident was ready. The family member stated that the resident was not responding to him/her at all. The family member stated they would like to talk with the doctor. Staff explained they could text page the doctor, to inform the doctor of the situation, and staff would give the doctor the family member ' s information. At 9:54 PM, staff text paged the doctor. At 10:10 PM, the doctor returned the call; advised to let the family member know the resident could be brought back to the skilled nursing unit for readmission and to reinstate the previous orders at this time. At 10:15 PM, staff called the family member and informed the family member the doctor advised that the resident readmitted back to the skilled nurse unit. The family member stated he/she was going to call EMS at this time. At 10:30 PM, the resident readmitted to the facility via EMS. Staff recorded the resident as alert to self, responding appropriately to questions by this nurse; physical assessment completed and noted to intervention list at this time. The resident was incontinent with a brief on. At 11:10 PM, staff recorded the resident currently rested quietly in bed with his/her eyes closed, displayed no signs/symptoms of distress or discomfort at this time, and staff set his/her bed alarm.

Staff recorded in the skilled nursing notes on 5/9/14 at 10:55 PM, the resident as oriented to self, with a bed alarm present and no pain present. The resident returned to the skilled nursing facility via EMS cart at 10:40 PM and transferred to bed. The resident's vital signs within normal limits. Staff conducted a physical assessment at this time and noted to intervention list. Staff changed the resident from sweat pants and shirt to a gown, and changed the resident's brief wet. The resident responded appropriately to questions, but was unable to state place or time.

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F 323	Continued From page 57 The resident displayed no signs/symptoms of distress or discomfort at this time. The EMS run form of 5/9/14 recorded at 11:03 PM - Received a call at 10:20 PM, arrived on the scene at 10:23 PM and reached the resident at 10:24 PM. The resident's extremity assessment was unremarkable. EMS was met at the front door by a family member. The family member stated the resident should not have been discharged from the hospital as the resident could not walk. The family member led EMS to a back bedroom to find the resident laying in bed. The resident slept, snoring, and awakened to voice. The resident was alert and oriented times 4. The resident was a direct admit to the skilled nursing facility, and had a pain level recorded as zero. Staff recorded on the 5/10/14 activities of daily living documentation at 2:53 AM, bed alarm was not needed and the resident required 2 person physical assist. Staff recorded in the 5/10/14 nursing notes at 4:40 AM - The resident's family member R called to check on the resident, and he/she was surprised by the decline of the resident since Tuesday (5/6) when the family member talked to the resident on the phone. The family member stated at that time the resident talked clearly; however stated the resident had just moved a piano and asked if the resident's friend knew the resident would be later for practice. This nurse informed the family member R that Thursday night (5/8/14), the resident explained to staff the resident parked the car and asked if that would be OK. Staff documented since arrival back on skilled nurse facility at 10:40 PM, the resident moaned as if in pain. The family member stated	F 323		

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he/she felt the resident's pain caused by the fact that when leaving the hospital to get into car, he/she was unable to get the resident in the car, the resident had to rest the resident's hip on the running board of the car until EMS could help lift the resident in the car. The family member reported the transfer of getting the resident in the car took approximately 15 minutes. The family member stated when the resident arrived home, it took 6 people including EMS to get the resident from the car in the house and into a chair. The family member stated they arrived home at approximately 3:30 PM unit.

Staff recorded in the 5/10/14 nursing notes at 5:57 AM, the resident woke to name and light touch at this time and displayed no signs/symptoms of discomfort, voiced no other needs at this time.

Staff recorded the use of a bed alarm on the 5/10/14 skilled nurse flow sheet at 9:38 AM. The resident denied any needs other than wanting to go to sleep.

Staff recorded on the 5/10/14 skilled daily assessment at 9:41 AM the resident was oriented to person, with full range of motion. At 12 noon, the resident sat up in the chair for lunch.

Activities of daily living documentation; on 5/10/14 at 3:01 PM, revealed the resident required 2 person physical assist for transfers, walking in the room/hall did not occur, and the resident used a bed alarm.

Skilled nursing notes, on 5/10/14 at 9:54 PM and 5/11/14 at 5:12 AM, recorded no pain present.

Skilled nursing notes, on 5/11/14 at 12 noon,

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recorded the resident voiced no needs.

Staff recorded in the 5/12/14 skilled nurse flow sheet at 4:55 PM, no pain present.

Staff recorded in the OT (Occupational Therapy) restorative note of 5/12/14 at 8:43 AM, diagnosis of weakness/falls. No pain present. Left lower extremity range of motion deficit within normal limits and required moderate assistance needed for transfer.

The PT (physical therapy) inpatient evaluation on 5/12/14 at 10:55 AM, recorded the resident had left and right lower extremity range of motion 50% deficit. Range of motion comments - The resident had a hard time moving his/her lower extremity due to an increase in stiffness. The resident was unable to support self in standing. The resident required maximal assistance with transfer support provided. The resident had decreased weight shift left, observed gait dysfunction. Gait comments - the resident scissored. The resident was unable to follow one step command due to confusion. The resident had poor sitting and standing balance, with complaints of pain.

Skilled nurse flow sheet on 5/12/14 at 12:20 PM documented the resident was up in the chair for lunch. The family member R was at the resident's bedside who stated, "We really should get an x-ray of the left leg and foot."

Review of the resident's ECR lacked evidence staff acted upon the resident's family member's request for an x-ray of the resident's left leg and foot.

Physical therapy notes on 5/12/14 at 3:40 PM

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documented the resident had difficulty in standing and putting weight on both lower extremities, due to complaints of pain present. The resident was unable to rate his/her pain. The resident was unable to assist or actively participate with sit to stand, needed verbal and tactile cueing in performing standing with 2 person assist, with maximum assistance. The resident was not totally putting weight on the left lower extremity.

The skilled nurse flow sheet, dated 5/12/14, at 8:39 PM and on 5/13/14 at 5:53 AM, documented, no pain present.

The skilled daily assessment on 5/13/14 at 8:55 AM, documented the resident was oriented to person, gait/transferring as weak and had full range of motion. Staff recorded on the skilled daily assessment on 5/13/14 at 9:35 AM, the resident exhibited full range of motion. At 12:33 PM, staff documented the resident sat up in the chair feeding self lunch, with no signs/symptoms of distress.

Staff recorded in the inpatient physical therapy treatment note on 5/13/14 at 3:10 PM, the resident had difficulty in standing and putting weight on both lower extremities due to complaints of pain, and the resident was unable to rate the pain. The resident was unable to assist or actively participate with sit to stand, needed verbal and tactile cueing in performing standing with 2 person assist, maximum assist. The resident was not totally putting weight on the left lower extremity, but was able to put both feet down on the floor while using the urinal.

Staff recorded in the skilled nurse flow sheet on 5/13/14 at 5:32 PM, the resident was unable to rate pain and resting in bed, without

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F 323	Continued From page 61 signs/symptoms of distress. On 5/14/14 at 10:30 AM, the resident's physician ordered a X-ray of the hips to rule out a fracture. The 5/14/14 x-ray report of the resident's bilateral hip joints and anterior/posterior pelvis recorded the resident had an acute left hip fracture of femur with 2.5 cm (centimeter) overriding. On 5/14/14 at 11:15 AM, the physician ordered the resident transferred to acute care with a diagnosis of a left hip fracture. Review of the physician's hand written progress notes were as follows: 5/6/14 at 8:25 AM - Will discuss with (significant other) nursing home placement. 5/9/14 - Fell yesterday while trying to get up from chair. Discussed with family member. Review of the physician's progress notes lacked evidence staff informed the family member of the resident's 5/8/14 fall. 5/12/14 - Brought back to SNF (skilled nursing facility). Significant other's inability to take care of the resident at home. 5/13/14 at 2:45 PM from urologist - Having difficulty standing. On 5/20/14 at 9:20 AM, observation revealed the resident in the shower with direct care staff C. Observation revealed the resident wore a yellow bracelet on the right wrist which read Fall Risk. Observation revealed a yellow star on the outside of the resident's door to indicate a fall risk. At 11 AM, observation revealed the resident in a chair in the room with a chair alarm in place. Direct care staff C verified the resident had a chair alarm in place and detached the alarm cord which activated the alarm to ensure proper function.	F 323		

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F 323	Continued From page 62 On 5/14/2014 at 12:27 PM, licensed staff K stated staff suspected the resident fell at home last Friday and fractured his/her left hip. Staff was not able to verify that. The resident fell last Thursday when he/she was here. On 5/20/14 at 7:22 AM, licensed staff I stated the resident fell on the day shift on 5/8/14 and now had a fractured hip. He/she was more active during the day, and a fall risk. If the resident had previous falls, we put that in the record in the assessment. The computer tallied a number for the fall risk. The resident had a yellow bracelet for fall risk and a star on the outside of the doorway, bed alarm and side rails up. I don't know about a chair alarm when he/she fell. On 5/21/14 at 11:05 AM, therapy staff H stated, I told the nurse when we stood the resident up that he/she could not stand and I asked if an x-ray had been done. They told me they did not do an x-ray. On 5/13/14 I could see facial expressions that the resident had pain. He/she would not put any weight on his/her left leg. On 5/21/14 at 11:16 AM, licensed staff L stated normally physical therapy told them and documented in the notes if the resident had pain. I worked on 5/12/14, and another nurse worked on 5/13/14. At that time, licensed staff L looked in the computer for the nursing notes on 5/13/14, and reported the nurse on duty on 5/13/14 recorded the resident was unable to rate his/her pain. On 5/9/14, direct care staff assisted the resident to a private vehicle. Licensed staff L looked in the ECR and verified he/she could not find any discharge note done on 5/9/14. This licensed staff verified the record lacked any discharge notes for 5/14/14 when the resident	F 323		

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transferred to acute care. This licensed staff stated the physician ordered an x-ray as (the family member) kept saying something was wrong with the resident's left leg. When you did not touch the resident's leg, he/she did not complain of pain. The resident's mobility had not changed. The resident was a transfer with 1 person assist. The resident had only the one fall on the unit.

On 5/21/14 at 11:30 AM, direct care staff C stated the resident's family member R and I took the resident out in a wheelchair. He/she did not stand very well. He/she was kind of out of it that day. I put the resident in the front seat. He/she leaned against the console between the front seats, I went and got more help. I did not drop the resident. I went and got the nurse from ER (emergency room). We couldn't get the resident in the car either. Then the ER nurse went and got EMS staff who helped us put the resident into the car. It took 4 EMS staff, me and the ER nurse to get the resident in the car. The resident did not complain of pain, but kind of moaned. I was not working on the day the resident fell. The resident was a little hesitant to put weight on his/her left leg when assisting him/her into the car.

On 5/21/14 at 2:32 PM, administrative licensed staff A stated staff should receive the x-ray report on the same day the x-ray was done. The physician and I were not aware of the discharge incident in the car. The doctor nor I were aware of the fracture until 5/15/14. X-ray normally calls immediately, but no one in x-ray called. There was no follow-up documented for the resident's family member's request for an x-ray on 5/11/14 at 5:22 PM.

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F 323	Continued From page 64 On 5/21/14 at 3:09 PM, licensed staff B (nurse on duty on 5/8/14 when the resident fell) stated it was lunch time. The resident was up in the chair with the over bed table over his/her lap. The staff heard a loud noise and the call light went off. The roommate had turned on the call light. I checked the resident before staff got him/her up, didn't find any injuries and assisted the resident to bed. I text paged the doctor, and we kept checking on the resident. The on-call doctor came up and checked on the resident after the fall. On 5/22/14 at 8:11 AM, physician D, stated he/she saw the resident the day after the fall, on Friday, 5/9/14. The family member thought he/she could take responsible care of him/her. I did not make the resident walk that day he/she discharged. I got a phone call on 5/9/14 around 10 PM that the DPOA wanted to bring the resident back to the hospital. I saw the resident on 5/10/14 and ordered labs (laboratory work). He/she stated the family member said it was hard for the resident to walk or talk. He/she had dementia, a history of decreased mental status, and not being able to walk. Physician D stated he/she stated I did not connect that with the fall on 5/8/14. The family member called my office nurse on 5/14/14 and requested an x-ray. My nurse's text message was that the family member had talked with the nurses at the hospital with no response so the family member called the office. The family member stated that every time the nurse moved the resident, he/she screamed in pain, and wanted to know if you would order an x-ray of the resident's left hip. My nurse's message read the family member was very concerned. The physician stated he/she responded to the texted page at 10:25 AM to tell the family member that he/she would take care of it. The physician stated he/she then ordered	F 323		

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F 323	Continued From page 65 bilateral hip x-rays which were done 10 minutes later with results of a left hip fracture. I talked to licensed staff K and asked him/her how the resident fractured his/her hip. At that time, physician D stated he/she found out about the 5/9/14 incident which took 6 people to get the resident in the car on the 5/9/14 discharge. The fracture probably happened either on the 5/8/14 fall or on the 5/9/14 car incident. The 2.5 cm overriding of the fracture indicated a delay in identifing the fracture. The treatment may not have changed due to the delay. On 6/2/14 at 3:30 PM, family member R stated the resident arrived home on 5/9/14 around 3:30 PM. Four EMS staff carried the resident in the house and placed the resident in bed. This family member R stated he/she left the house at 4:50 PM where the resident remained in bed. This family member state he/she returned home around 8:05 PM, and the resident remained in bed, in the same position when he/she had left the resident This family member stated the resident was not able to get out of bed by their self and had no falls while at home for the brief period of time. The facility failed to implement fall prevention interventions, as planned, for this cognitively impaired, dependent resident who had a fall and sustained a hip fracture. - Observation of the rehabilitation room, on 5/14/14 at 9:35 AM identified a hydrocollator (a hot water heater for warming hot packs for heat therapy) plugged into a regular electrical outlet. On 5/22/14 at 7:45 AM, maintenance staff Q, stated he/she was not sure the electrical outlet	F 323		

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F 323	Continued From page 66 was a GFCI outlet (ground fault circuit interrupter-used for applications with potential water contact to prevent electrical shock) or not and then asked another maintenance staff. At 7:55 AM, staff Q verified the electrical outlet was not a GFCI outlet and stated they would disconnect the hydrocollator until the outlet could be replaced. On 5/22/14 at 9:00 AM, observation revealed a piece of unsecured carpet in the therapy area of the day room. Observation revealed this piece of carpet lacked any type of device to secure the edges to prevent tripping, and the back of the carpet lacked any type of device to secure the carpet to the floor to prevent slipping. On 5/22/14 at 9:03 AM, housekeeping staff P, verified the carpet loose and unsecured. The facility failed to maintain a safe and secure environment for the residents of the unit when they failed to install a GFCI outlet, near a water source, and failed to secure a loose piece of carpeting to prevent tripping.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 67 This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview and record review, the facility failed to adequately monitor and ensure proper weight recording for 1 resident (#9) of 3 reviewed for nutrition. Findings included: - The facility admitted resident #9 on 4/24/14 per the ECR (electronic care record). The 5/11/14 admission MDS (minimum data set) assessment identified the resident scored 15/15 on the BIMS (brief interview for mental status) assessment, indicating intact cognition. The resident was independent with eating after set-up help by staff. The 5/11/14 CAA (care area assessment), identified the resident's BMI (body mass index) indicated the resident overweight for his/her height and on a diabetic diet. The 5/22/14 dated care plan, instructed staff the resident needed a dietary assessment, a dietician assessment, weekly weights, and meal intake assessments. The care plan lacked specific instructions related to the resident's diet orders, as noted on the dietician assessment dated 4/24/14. The 4/24/14 dietician assessment, documented the staff to provide the resident with the physician ordered 1800 ADA (American Diabetic Association) diet, and to include lactose intolerant, with small amounts of dairy acceptable, and the resident enjoyed soy milk.	F 325		

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F 325	Continued From page 68 Weights, as recorded in the ECR, included: 1. On 4/24/14, a weight of 277 pounds, by bed scale. 2. On 4/28/14, a weight of 260 pounds, by Hoyer lift scale. 3. On 5/5/14, a weight of 244 pounds, by standing scale. 4. On 5/6/14, a weight of 242 pounds, by standing scale. 5. On 5/13/14, a weight of 263 pounds, by standing scale. The 4/27/14 dietary assessment, identified no swallowing problems, the resident received a therapeutic diet, and without a history of weight loss. A 5/11/14 dietary assessment, identified the resident with "some" weight loss, partially related to the resident's diet, for better weight management. The assessment additionally identified the patient planned to discharge home and identified the resident as a low nutritional risk. On 5/14/14 at 10:55 AM, the resident noted up and walking from the bathroom, and seated his/herself into the wheelchair for discharge from the unit. The resident appeared in stable health, at that time. On 5/20/14 at 7:15 AM, direct care staff J reported the resident received bedtime, diabetic snacks. The staff further reported a lack of knowledge of the resident experiencing any	F 325		

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F 325	Continued From page 69 weight loss. On 5/21/14 at 11:47 AM, direct care staff C, reported a lack of awareness the resident experienced a weight loss. Licensed nursing staff L, on 5/22/14 at 4:10 PM, when asked if the resident experienced weight loss, indicated the resident experienced some weight fluctuations, but nothing significant. Upon staff L observing the resident's actual weight recordings, as noted above, staff L stated, the staff should have checked into the reason for the discrepancy in the weights. When direct care staff weigh the residents, they are to report to the charge nurse about any changes in the weights. On 5/22/14 at 12:35 PM, dietary staff N, reported the residents ' weights are monitored upon admission, then at 3, 5, and 10 days if deemed at risk. The staff identified they did not consider the resident at risk for weight loss, due to the BMI. On 5/22/14 at 6:30 PM, licensed nursing staff B, reported he/she would expect nursing staff would identify and investigate the reason for the weight difference for a resident documented as experiencing a 33 potential pound weight loss. The facility failed to adequately monitor the weight of this resident; failed to identify the inaccurate weight recordings and investigate to determine the residents actual weights, when the staff recorded weights indicating the resident experienced a 33 pound weight loss during the 19 day stay in the facility.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with	F 327		

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F 327	Continued From page 70 sufficient fluid intake to maintain proper hydration and health. This Requirement is not met as evidenced by: The facility reported a census of 13 residents with 17 selected for sample review. Based on interview and record review, the facility failed to ensure one resident (#43) of one reviewed for hydration, received adequate monitoring of hydration status. Findings included: - The facility admitted resident #43 on 3/6/14, per the ECR (electronic care record) and discharged the resident to a hospice service on 3/18/14. Diagnosis from the ECR included congestive heart failure (a condition with low heart output and the body becomes congested with fluid). The resident's 5 day MDS (minimum data set) assessment, dated 3/12/14, identified the resident scored 10/15 on the BIMS (brief interview for mental status) assessment, which indicated moderately impaired cognition. The resident required supervision and set-up help only for eating, without any swallowing concerns, received a therapeutic diet, and identified dehydration concerns with output exceeding intake. The resident's 3/18/14 care plan, instructed staff to maintain fluid restrictions, I & O (intake and output), skilled meal intake assessments, and daily weights. Review of the physician orders, dated 3/6/14, included monitoring of I & O every shift. The I & O records in the ECR recorded:	F 327		

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F 327	Continued From page 71 On 3/6/14, intake of 480 ml (milliliters), with output of 900 ml, which reflected a 420 ml fluid deficit. On 3/7/14, intake of 720 ml, with output of 800 ml, which reflected an 80 ml fluid deficit. On 3/8/14, intake of 360 ml, with output of 650 ml, which reflected a 290 ml fluid deficit. On 3/9/14, intake of 720 ml, with output of 450 ml, which reflected a fluid deficit of 270 ml. On 3/10/14, intake of 240 ml, with output of a 240 ml overage, based on the numbers available. On 3/11/14, intake of 360 ml, with output of 850 ml, which reflected a 490 ml fluid deficit. On 3/12/14, intake of 390 ml, with output of 500 ml, which reflected a 110 ml fluid deficit. On 3/13/14, intake of 720 ml, with output of 850 ml, which reflected a 130 ml fluid deficit. The remaining documented intakes and outputs, lacked output amounts, due to incontinent brief usage, and therefore were inconclusive. On 5/20/14 at 7:25 AM, direct care staff J reported the residents are offered fluids during cares, unless the resident had a fluid restriction. Staff reported a lack of awareness of the resident's fluid status. On 5/21/14 at 11:47 AM, direct care staff C reported recalling the resident exhibited shortness of breath and recalled the resident required I & O documentation every shift.	F 327		

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F 327	Continued From page 72 Licensed nursing staff B reported on 5/22/14 at 2:15 PM, the resident was not compliant with fluid restrictions, however, the resident required I & O monitoring. Upon review of the I & O recordings in the ECR, staff B acknowledged the facility failed to adequately measure intake and output and expected the nursing staff would review the I & O every shift and would contact the physician with fluid deficits of the larger quantities, especially the 420 ml deficits. The facility failed to adequately monitor and assess the resident ' s hydration status needs, when the staff failed to adequately review and record fluid intake and outputs, as ordered.	F 327		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This Requirement is not met as evidenced by:
The facility reported a census of 13 residents. The 17 residents selected for review included 5 reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure 5 of 5 residents reviewed remained free of unnecessary medications including; (#62) for bowel monitoring; (#60) for blood sugar and blood pressure monitoring and prn (as needed) pain medication follow-up; (#67) for follow-up on prn pain medication monitoring.

Findings included:

- The facility admitted resident #60 on 5/2/14, per the ECR (electronic care record), with diagnoses including; diabetes mellitus, Type II, with long term use of insulin (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), and pain.

The 5 day MDS (Minimum Data Set), dated 5/5/14, recorded a BIMS (brief interview for mental status) score of 15/15, indicating intact cognition, and the resident received injections 7 days, and the physician changed the insulin orders 4 times in the prior 7 days.

The 5/2/14 initial care plan, included the following interventions:
1. Complete medication reconciliation.
2. Record of teaching.
3. Teach dietary management.
4. Blood glucose assessment at 7 AM, 11:30 AM

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F 329	Continued From page 74 and 4:30 PM. Review of the Physician admission orders on 5/2/14, included: 1. Fasting blood sugar monitoring four times daily. 2. Call doctor if blood sugar less than 100 or over 250. 3. Tenormin, 25 mg (milligrams), by mouth, daily, for hypertension. 4. Hydrocodone, 7.5/325 mg, three times daily, PRN (as needed) for pain. Review of the ECR identified the following recorded information related to blood sugar monitoring: Elevated Blood sugars: On 5/3/14 at 9:13 PM, blood sugar level of 330. On 5/8/14 at 8:22 PM, blood sugar level of 264. On 5/11/14 at 4:19 PM, blood sugar level of 253. Low Blood sugars: On 5/3/14 at 6:18 AM, blood sugar level of 85. On 5/3/14 at 11:21 AM, blood sugar level of 74. On 5/8/14 at 6:04 AM, blood sugar level of 80. On 5/9/14 at 7:10 AM, blood sugar level of 76. On 5/10/14 at 12 noon, blood sugar level of 80. On 5/11/14 at 11:52 AM, blood sugar level of 85. On 5/12/14 at 6:35 AM, blood sugar level of 63. On 5/12/14 at 11:39 AM, blood sugar level of 75. On 5/13/14 at 6:32 AM, blood sugar level of 70. Documentation in the ECR lacked identification of the staff notifying the physician, as ordered, for the above blood sugars outside of the parameters established, by the physician. Review of the Vital Signs recorded in the ECR revealed the following B/Ps (blood pressures): On 5/2/14 at 4 PM - 116/55, sitting.	F 329		

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F 329	Continued From page 75 On 5/2/14 at 8:44 PM - 102/56, sitting. On 5/3/14 at 6:45 AM - 99/49, supine. On 5/4/14 at 5:11 AM - 91/52, supine. On 5/5/14 at 6:40 AM - 110/59, supine. On 5/6/14 at 4:47 PM - Supine 162/81; sitting 150/94; standing 159/99. On 5/8/14 at 6:40 AM - 110/54 sitting. On 5/9/14 at 5:57 AM - 113/56 supine. On 5/10/14 at 5:51 AM - 93/66 supine. On 5/11/14 at 8:30 AM - 117/55 sitting. On 5/12/14 at 6:31 AM - 126/57 supine. On 5/13/14 at 5:58 AM - 98/55 sitting. On 5/14/14 at 5:45 AM - 123/58 supine. On 5/15/15 at 6 AM - 121/59 sitting. An undated posted sign on the door to the staff breakroom and the staff bathroom instructed staff of the need to inform the physician of systolic BP readings of less than 100 or over 140 and diastolic BP readings less than 60 or over 85. The sign instructed staff BP's recorded outside of the range, must be reported to the nurse. The signage further stated to wait 5 minutes and recheck with a manual BP cuff and the nurse will make a judgment of what to do if the next vitals are abnormal. Documentation in the clinical record, reviewed from 5/2-22/14, lacked identification of the physician being notified of these abnormal BP readings. Review of the ECR for medication administration, from 5/2-22/14, identified the following concerns regarding PRN and the facility failure to follow-up with assessments for Hydrocodone 7.5/325 mg, three times daily, PRN for pain as follows: Administered on 5/8/14 at 6:07 AM, by prior shift with pain rated at 8 for left foot pain; documented	F 329		

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not reassessed at 7:07 AM, due to prior shift administered.

On 5/9/14 at 5:45 AM, with pain rated at 7 in the left foot with reassessment on 5/9/14 at 6:45 AM, not done for undetermined reason.

On 5/13/14 given at 6:47 PM, with pain rated at 7 in the left foot, reassessment on 5/13/14 at 7:47 PM, documented not done -- administered by previous nurse.

The staff failed to reassess the resident for PRN pain medication effectiveness on these 3 occasions.

On 5/20/14 at 7:15 AM, direct care staff J reported residents known to have diabetes are monitored for signs of hyper/hypoglycemia such as sweating, frequent urination or a change in their level of consciousness. Staff reported they would tell the nurse if they noted any of these signs.

On 5/20/14 at 7:22 AM, licensed nursing staff I, reported working on the night shift, and they completed blood sugar monitoring as ordered. Staff I further stated the parameters for each resident are established by the physician and documented in the ECR for when the physician wants to be notified. Also, there is always an ER (emergency room) physician available, 24 hours per day.

On 5/20/14 at 11:33 AM, licensed nursing staff B, stated staff should have sent the doctor a text page for each of the high/low blood sugar readings noted, then documented the text page in the ECR.

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F 329	Continued From page 77 On 5/20/14 at 2:30 PM, direct care staff T stated residents with BP's over 140 or below 60 are reported to the nurse. Then, the nurse will go and assess the resident or the direct care staff will do a manual BP, after direct care staff tell the nurse. Staff T further explained the direct care staff document the vital signs in the computer. On 5/20/14 at 2:40 PM, licensed nursing staff L, stated the CNA's (certified nurse aides) do the vital signs. Nurses are to notify the physician if the systolic BPs is above 140 or less than 100; or if the diastolic BP's are above 85 or below 60. Most generally the resident is on BP medications. The aides tell the nurses the vitals and give the nurses the vital sign paper. The nurse looks to see if the resident is on a BP medication and if no prn orders exist, then we text page the physician. Staff L reported the nurses do the same system with residents ' blood sugars. Nurses are to document under interventions or in nursing notes of the notification. On 5/20/14 at 2:48 PM, administrative licensed nurse A stated, elevated BP or BPs out of parameter would necessitate the nurse to document actions. Staff A reviewed and then verified the resident's ECR lacked evidence of documentation of any action taken in regards to the BPs out of parameter range to notify the physician. On 5/20/14 at 5:45 PM, administrative nurse A, reported he/she had not been able to verify any doctor text pages regarding the out of range blood sugars. On 5/22/14 at 1:15 PM, pharmacy staff M, stated licensed nursing staff are required to do a follow-up pain assessment, for effectiveness,	F 329		

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after administering prn pain medications.

The facility policy for Vital Signs, Blood Pressure, dated 8/9/05, instructed staff to report abnormal readings.

The facility policy for pain management, dated 7/1/09 instructed staff the resident would be assessed and documentation would occur, after each pain management intervention, once a sufficient time has elapsed for the treatment to reach peak effect.

The facility failed to appropriately monitor the resident and notify the resident's physician, as ordered, for blood sugar and blood pressure monitoring. Additionally, the facility failed to monitor the resident for the effectiveness of PRN pain medication administration, to ensure the resident remained free of unnecessary medications and received effective pain control.

- The facility admitted resident #62 on 4/6/14, per the ECR (electronic care record).

The resident's 14 day admission 4/23/14 MDS (Minimum Data Set), recorded a BIMS (brief interview for mental status) score of 3, indicating the resident severely impaired of cognitive status. The resident required limited assistance of 1 person with bed mobility and required extensive assistance of 2 staff with transfers and toileting.

The 4/6/14 care plan, lacked instructions related to the resident bowel habits/needs.

Review of the resident's physician orders included the following medications related to bowel function.

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F 329	Continued From page 79 On 4/6/14, Colace, 100 mg (milligrams), BID (twice daily) for constipation. On 4/23/14, Fleets enema once for constipation. BM (bowel movement) monitoring lacked identification of a BM or the facility providing any additional interventions to facilitate a BM, from 4/24/14 until 5/1/14, for 7 days. Direct care staff C reported on 5/21/14 at 11:42 AM, the direct care staff (or nurses, if present) document BM's into the ECR. Then, daily the licensed nurses are checking to ensure all residents are having routine BM's. Sometimes the CNAs (certified nurse aides) also look into the computer and if seeing a resident did not have a BM for a few days, they would tell the nurse. On 5/22/14 at 5 PM, licensed nursing staff B stated, the nurses or the aides check the BMs and if no BM for several days, then the nurse calls the physician. On 5/22/14 at 5:03 PM, administrative nursing staff A stated, the unit's BM policy was if no BMs in 3 days, assess and notify the doctor. On 5/22/14 at 5:30 PM, licensed nursing staff B verified the resident did not have any BM's from 4/24/14 until 5/1/14, and that the facility failed to provide medications/interventions to assist the resident with having a BM, and failed to notify the physician, as planned. The facility, 12/8/11, Bowel movement monitoring policy, instructed staff that residents who do not have a bowel movement after three consecutive days, will be referred to the licensed nursing staff and the physician will be notified for orders or	F 329		

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F 329	Continued From page 80 PRN medications will be given. The facility failed to ensure the staff regularly assessed the resident bowel activity and failed to notify the physician, as needed to ensure no unnecessary medications for the resident. - The facility admitted resident #9 on 4/24/14 per the ECR (electronic care record) with diagnosis including: cerebrovascular accident (Cerebrovascular accident (CVA-stroke- A sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and hypertension (elevated blood pressure). Physician's orders revealed the following medications with black box warnings: 1.) Warfarin, 2 mg (milligrams), daily for preventative, ordered on 5/13/14. According to www.fda.gov <http://www.fda.gov>, Warfarin had a black box warning of bleeding risk. Warfarin can cause major or fatal bleeding. Perform regular monitoring of labs in all treated patients. 2.) Metoprolol Succinate, 25 mg (milligrams), daily, for hypertension, ordered on 4/26/14. According to www.fda.gov <http://www.fda.gov>, Metoprolol had a black box warning of ischemic heart disease (reduced blood supply to the heart). The 4/24/14 care plan, lacked instruction in care needs including the monitoring of the resident for adverse consequences associated with the administration of these 2 medications with black	F 329		

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F 329	Continued From page 81 box warnings. Licensed nursing staff B, on 5/22/14 at 5:40 PM, reported the pharmacy is supposed to post the appropriate black box warning on the MAR (medication administration record) for the medications that require black box warnings. The staff reported the current computer system did not allow the addition of black box warnings into the care plan. The facility failed to identify and monitor the resident for the adverse consequences associated with the administration of these medications with black box warnings for this resident. - The facility admitted resident #63 on 5/1/14 per the ECR (electronic care record). Review of the physician orders included the following medication with black box warning: 1.) Metoprolol Tartrate, 25 mg (milligrams), twice daily, ordered on 5/21/14, however, the medication had been ordered on 5/1/14 at 50 mg twice a day. According to www.fda.gov <http://www.fda.gov>, Metoprolol had a black box warning of ischemic heart disease (reduced blood supply to the heart). The 5/1/14 care plan, lacked instruction in care needs including the monitoring of the resident for adverse consequences associated with the administration of this medication with a black box warning. Licensed nursing staff B, on 5/22/14 at 5:40 PM,	F 329		

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F 329	Continued From page 82	F 329		

reported the pharmacy is supposed to post the appropriate black box warning on the MAR (medication administration record) for the medications requiring black box warnings. The staff reported the current computer system did not allow the addition of black box warnings into the care plan.

The facility failed to identify and monitor the resident for the adverse consequences associated with the administration of this medication with a black box warning.

- The facility admitted resident #67 on 5/9/14, per the ECR (electronic care record) with diagnoses including pain.

Physician's orders revealed the following medications ordered for pain control, included:

1.) Oxycodone/Apap (acetaminophen), 5/325 mg (milligrams), every 4 hours, prn (as needed) for pain, ordered on 5/12/14.

Review of the administration of the medication for the resident's stay at the facility, from 5/1/14 through 5/16/14, included the medication provided to the resident on 5/13/14 at 5:57 AM, and the staff failed to reassess for the effectiveness of the prn administration for the resident's pain.

2.) Ibuprofen, 800 mg., three times daily, prn pain, ordered on 5/9/14.

Review of the administration of the medication administered from 5/1/14 through 5/16/14, revealed the medication administered on 5/11/14, 5/12/14, and 5/13/14. However, the staff failed to

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F 329	Continued From page 83 reassess the resident's pain following the pain medication administration to determine the effectiveness of the medication related to the pain. The 5/9/14 care plan lacked instruction to staff regarding the administration of pain medications and the need for follow-up assessment. On 5/21/14 at 2:30 PM, licensed nursing staff L reported the computer system for the use of pain medication of Ibuprofen and Tylenol lacked a tracking method for the follow-up assessment on pain effectiveness. Additionally, the staff reported that continuity of care dictated that any pain medication administered required follow-up documentation as to the effectiveness of the medication to ensure the resident's pain control guidelines are met. Administrative nursing staff A, reported on 5/21/14 at 3:11 PM, all pain medications required follow-up for effectiveness of the medication. Consulting staff M, reported on 5/22/14 at 1:20 PM reported the resident needed a pain reassessment, when administering a prn medication, no matter what type of medication was administered. Staff M reported this feature was available in the computer and needed staff education in the method of input. The facility failed to ensure the resident received appropriate follow-up assessment of prn pain medication for effectiveness on 4 occasions, during the resident's stay in the SNF.	F 329		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		

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F 334	Continued From page 84 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		

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F 334	Continued From page 85 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review, included 5 reviewed for immunizations. Based on interview and record review, the facility failed to ensure the residents of the facility received an offer of vaccination, education related to the vaccines, and documentation of the 5 resident's influenza and pneumococcal immunization status for (#60, #67, #39, #61 and #65) reviewed. Findings included: - On 5/20/14 at 7:45 AM, review of the following resident's immunization records identified the following concerns: 1. Resident #60's, vaccination records, in the	F 334		

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F 334	Continued From page 86 adult admission assessment, identified the resident refused the influenza vaccination and indicated a prior vaccination for pneumococcal vaccination. However, the facility failed to identify in the resident's ECR (electronic care record) the evidence of providing the resident educational material regarding vaccinations. 2. Resident #67's vaccination records, in the adult admission assessment, identified the resident received the influenza and pneumococcal vaccinations. However, the facility failed to identify the dates of the vaccinations to ensure timeliness of the vaccinations. 3. Resident #39's vaccination records, in the adult admission assessment section of the ECR identified the resident reported a prior history of influenza and pneumococcal vaccination. However, the facility failed to identify the dates of the vaccinations to ensure timeliness of the vaccinations. 4. Resident #61's vaccination records, in the adult admission assessment section of the ECR, identified the resident reportedly refused influenza and pneumococcal vaccinations. However, the ECR failed to identify the facility provided educational material regarding the vaccinations, as required. 5. Resident #65's adult admission assessment, in the ECR identified the resident's daughter reported the resident declined vaccinations for influenza and pneumococcal vaccinations. However, the ECR lacked evidence of educational materials provided to the resident and/or the durable power of attorney, for an informed decision, regarding the resident's vaccinations.	F 334		

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F 334	Continued From page 87 Interview with administrative nursing staff A, on 5/20/14 at 7:45 AM, reported the patients usually are interviewed regarding vaccinations during the acute hospital stay and the SNF (skilled nursing facility) only transfer that information from the acute stay. The staff acknowledged the lack of a functional vaccination program to ensure the residents and their families receive information regarding the risks and benefits of the vaccination programs. The facility failed to ensure the residents of the facility received educational information regarding vaccination information for influenza and pneumococcal vaccinations and tracking of the vaccinations to ensure the resident received timely vaccinations, as required.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 13 residents. Based on observation, interview, and record review, the facility failed to store, prepare and serve foods in a sanitary manner, for the residents of the facility. Findings included:	F 371		

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F 371	Continued From page 88 The initial tour on 5/14/14 at 8:30 AM, in the kitchen identified the following concerns: 1. The hand sanitizer dispenser at the entrance into the kitchen failed to operate when activated. 2. A refrigerator, near the baking preparation area, contained a stainless steel pan with a thick green liquid spillage in the bottom. Inside of this pan and in direct contact with the liquid, observation revealed 2 opened packages of unlabeled and undated tortillas. 3. A half of an onion, sealed in an unlabeled and undated plastic bag, revealed the outer layers a brown and grayish discoloration to the outer skins. 4. A container of cheese sauce, dated 5/7/14, 7 days old in this refrigerator. 5. An opened box of liquid eggs, dated 5/6/14, contained a label with instructions to discard after 3 days. The eggs were 8 days old. 6. Roast beef, dated 5/9/14, and 5 days old, remained in the refrigerator. 7. Cream of mushroom soup, dated 5/8/14, 6 days old, remained in the refrigerator. The Kelvinator, Freezer contained: 1. Chicken pieces, dated 4/10, in a plastic bag, contained excessive frost with the chicken. 2. The entire inner surfaces, including shelves and walls exhibited a heavy frost build-up and various food spillage areas along the shelving of	F 371		

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F 371	Continued From page 89 the unit. The back dry store room's farthest exit door, held a sign instructing to keep the door closed. However, this evidenced an opened cover into a crawl space with a rubber hose, which ran from the crawl space along the floor of the dry storage area and through the opened back store room door into the parking lot, allowing an entrance for any type of pest/rodent/animal entrance into the dry food store area. The area was unattended by staff during the observation of the dry storage area. Additional concerns in the dry goods area revealed shelving throughout the area, wood as well as metal, in poor condition. The metal shelving exhibited rust and missing finish to the metal shelving and the wood shelving exhibited bare wood, where paint had peeled and/or chipped, creating a difficult to sanitize surface. Two of two walk-in coolers exhibited metal shelving with chipped paint revealing some rust surfaces, creating a difficult to sanitize surface. Additionally, 11 cartons of thawing liquid eggs, dated 4/10/15 lacked an expiration date, however, the label instructed to keep the item frozen. The label lacked a dispose of date after thawing. One of the 2 walk-in freezers exhibited food spillage on the floor of the unit, appearing as a round orange slice. One of 2 sheet metal doors, on the walk-in coolers, exhibited loose and hanging gray tape. The edges of the sheet metal gaped open, exposing the inner insulation of the door. Additionally, the sticky residue of the hanging tape remained on the door surface.	F 371		

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F 371	Continued From page 90 The heating and air conditioning unit standing in the kitchen area exhibited a heavy build-up of lint and dust on the exterior of the unit, with visible debris on the filter inside the unit. An additional storage area for pots and pans exhibited peeling/chipped paint to the storage shelves. A storage area containing file cabinets, exhibited boxes sitting directly onto the floor and excessive debris on the floor. The tilt skillet exhibited rusty areas under the enclosed unit. The Hobart pass-through refrigerator, evidenced a bag of browning lettuce, with an unreadable smeared date of 5/??. One (located near the triple sink) of 2 microwaves in the kitchen, exhibited spatters to the outer edges, including white spots of varying sizes from 1/2 inch to 1 inch diameter. The drying section of the dishwashing area, identified a fan, blowing directly onto the clean dishes, with a build-up of gray lint and dust, to the blades, as well as the inner and outer cage area. During sanitation tour on 5/22/14 at 7:15 AM, the following concerns were noted: 1. Observation of the serving table at the service line, lacked areas of lamination, exposing bare chipped wood along the exterior perimeter ranging from 1/4 inch to 1 1/2 inch wide. 2. A mixer in the preparation area, identified various sized/colored spots of food debris	F 371		

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F 371	Continued From page 91 (ranging in color from brown to white and size from 1 inch diameter to 1/2 inch). 3. The convection oven exhibited burnt on heavy debris, in some areas as much as 3/4 inch high, throughout the interior including the sides, bottom and the doors. The windows of the doors held so much burnt on debris the view into the unit was obscured. Dietary staff O reported the staff cleaned the oven this past weekend. 4. One of two microwaves, located near the grill area, held a heavy debris on the interior surfaces, including all sides, top, base and the glass plate for food placement. 5. The heating/air conditioning unit remained with heavy, fluffy, dark gray debris over the vents of the unit located in the kitchen preparation and serving area. Dietary staff O, reported this area was cleaned by the maintenance department, and the kitchen staff lacked awareness of the maintenance cleaning schedule for the unit, however, dietary staff placed a work order, on several occasions to have the unit cleaned, without success. Staff reported the unit in need of cleaning for a while now. 6. A glassed front refrigerator contained liquid spillage, orange in color, approximately 3 inches by 2 inches in size, in the base of the refrigerator. 7. Seven unopened cartons of thawing eggs, for scrambled eggs, lacked identification of the number of days stored in the refrigerator safely. Staff reported they lacked awareness of the number of days the items could be kept unfrozen. The label instructed, "Keep frozen." Dietary staff O reported on 5/22/14 at 7:45 AM	F 371		

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F 371	Continued From page 92 the cooked and then refrigerated items needed disposed of after 3 days and the items such as cheeses and condiments, are disposed of related to their expiration dates, marked on the items, by the manufacturer. The staff further reported a lack of knowledge of the length of time frozen items are kept. A fan blowing directly onto the clean dishes exhibited a build-up of dust on the interior edges of the fan cage and blades. The outer edges had been wiped off, at that time. Dietary staff O further reported the kitchen lacked a cleaning schedule, staff are expected to clean whatever needed cleaning. An undated, Food Service Worker Check List, provided by the facility identified, oven shelves clean of all spills, debris and brown buildup daily and thorough Tuesday and Friday AM Cook, Monday and Wednesday Cook and Saturday by weekend cook. The Cooks daily check list instructed staff daily to discard leftovers, as required. The daily check list further instructed staff to clean the microwave daily at the end of each shift of spills and splatter on the inside and wiped clean of smudges, spills, and spatters on the outside. The facility failed to store, prepare and serve foods in a sanitary manner for the residents of the facility.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	F 441		

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F 441	Continued From page 93 transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure adequate sanitization of a multi-use glucometer (machine to monitor blood sugar levels) and the kit for holding the	F 441		

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glucometer supplies and failed to administer medications to 1 resident (#64) in a sanitary manner. Furthermore, the facility failed to maintain an ongoing infection control program, to monitor, track and trend infections in the SNF (skilled nursing facility) to identify, investigate, control and prevent infections within the SNF.

Findings included:

- On 5/15/14 at 7:15 AM, observation revealed licensed nursing staff K performed a glucometer blood sugar check on resident # 70. Upon completion of the fingerstick, the staff placed the glucometer on top of the medication cart, with the test strip in place in the unit. Staff K then provided the resident the ordered insulin. The staff failed to provide any cleaning to the glucometer, before going into resident #60's room to administer their insulin. Staff K then took the medication cart to the nurse's station, removed the glucometer from the top of the medication cart, and placed the glucometer onto a base at the nursing desk. The staff failed to clean the glucometer at that time.

On 5/15/14 at 11:05 AM, licensed nursing staff L, completed a blood sugar glucometer check for resident #63. Staff L removed a container from the nurses desk area then entered the residents room and the container directly onto the resident's overbed table top. Staff L completed the glucometer check then exited the room with the container tucked under his/her arm, and entered resident #61's room. Staff L repeated the same procedure of placing the container directly onto the resident's bedside table, removed the glucometer unit from the container and performed the fingerstick. After completing the fingerstick the staff placed the unit, with the

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glucometer strip (containing blood from the fingerstick) onto the arm of the resident's chair. After completing the fingerstick, staff L removed the test strip with their gloved hands from the glucometer then stepped across the room to the sharps container to dispose of the used items, again placing the glucometer unit directly onto the nearby dresser. Staff sanitized his/her hands, and then picked up the unit from the dresser, returned the unit into the container with other supplies, and then carried the container out to the nurses desk, without any sanitization observed. Staff L, at 11:15 AM reported this as the normal routine for monitoring blood sugars. An additional interview with licensed nursing staff K and L, at that time, reported that the unit did not come into direct contact with blood; therefore, the unit did not require sanitizing between multiple resident uses.

On 5/20/14 at 2:30 PM, administrative nursing staff G, reported the nursing staff are trained at orientation and then yearly regarding cleaning of the glucometer unit. Staff G further reported the unit required wiping down with a disinfectant wipe between each resident.

Interview on 5/22/14 at 6:30 PM, with administrative nursing staff A, reported the staff are expected to sanitize the unit between each resident use with a sanitizing wipe and further reported the staff are expected to only take the minimum equipment required into the resident's room.

Review of the manufacturer's recommendation for the glucometer, revealed recommendations not for multiple resident use, but individual use, on cleaning the glucose monitoring machine, dated 1/11/2005, instructed staff to clean the unit

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with warm, soapy water and allowing it to air dry. The policy further noted, if a disinfectant was used, a 1:10 solution of bleach would be used.

Review of the disinfectant wipes, referred to as the disinfectant wipes by staff during interviews, identified, the wipes effective on killing bacteria and viruses and lacked identification of any bleach product in the wipes.

The facility failed to ensure a disinfecting program for the use of multi-use glucometer equipment, for the residents of the facility requiring blood glucose monitoring.

- On 5/15/14 at 8:50 AM, observation revealed licensed nursing staff K touched the touch pad on the medication cart computer, the scanner, drawers of the medication cart and plastic bags on the medication cart without any hand washing observed and then used an ungloved finger to reach into the pill containers of Zestril and Aspirin for resident #64, to retrieve the pills for administration. Staff K administered the contaminated medication pills to the resident's mouth.

The facility failed to ensure non-contaminated medications administered to this resident.

- On 5/20/14 at 2:30 PM, administrative nursing staff G reported the infection control program consisted of daily overview of antibiotics and micro lab, looking for multi-resistant drug organisms, isolation needs, wound tracking, and catheter reviews.

Administrative nursing staff G further reported on

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F 441	Continued From page 97 5/21/14 at 8:44 AM, the infection control program lacked a specific tracking and trending program for the unit and the staff could not provide additional information on tracking and trending for the SNF unit. Staff G reported the overall review of infection control is completed in conjunction with the entire hospital. The facility policy, titled Patient Safety, undated, included the facility monitored and tracked infections electronically with an annual risk assessment performed, and surveillance conducted hospital-wide. The facility failed to develop and implement an infection control program to review, analyze, manage and prevent the spread of infections to the residents of the unit, as part of an on-going infection control program.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520		

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F 520	Continued From page 98 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. Based on interview and record review, the facility failed to maintain a quality assurance committee that developed and implemented appropriate plans of action to identify quality of care concerns for the residents of the facility. Findings included: - The facility failed to have an effective quality assurance committee to meet the physical, mental, and psychosocial needs of the 13 residents as evidenced by: 1.) Refer to F- 221, the facility failed to ensure 1 resident (#63) of 3 reviewed for physical restraints, remained free of physical restraints imposed for staff convenience and not required to treat the resident for medical symptoms. 2.) Refer to F- 225, the facility failed to thoroughly investigate and report to the state agency, as required for 1 resident (# 62) of 1 reviewed for accidents who experienced a hip fracture of unknown origin. 3.) Refer to F- 241, the facility failed to maintain personal dignity for 1 (#65) of the 17 sampled residents, during meals and ambulation. Additionally, the facility failed to enhance each residents dignity, when the facility failed to	F 520		

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F 520	Continued From page 99 provide iced tea in glasses, during dining observation on 5/14/14, as a reasonable person would expect 4.) Refer to F- 248, the facility failed to provide an ongoing program of activities for the residents of the SNF (skilled nursing facility), including 3 (#68, #9, and #63) of the 3 residents reviewed for activities. 5.) Refer to F- 309, the facility failed to ensure 1 resident (# 34) of the 17 reviewed, received appropriate, physician ordered fluid restrictions. 6.) Refer to F- 312, the facility failed to provide necessary ADL assistance, for the 3 residents reviewed, including (# 59 and #66) for nail care and (#65) for dressing. 7.) Refer to F- 323, the facility failed to provide interventions as planned to prevent accidents for the only resident (#62) reviewed for accidents who experienced a fractured hip, and failed to ensure the residents' environment remained free from accident hazards in the rehabilitation room and the day room. 8.) Refer to F- 325, the facility failed to adequately monitor and ensure proper weight recording for 1 resident (#9) of 3 reviewed for nutrition. 9.) Refer to F- 327, the facility failed to ensure one resident (#43) of one reviewed for hydration, received adequate monitoring of hydration status. 10.) Refer to F- 441, the facility failed to ensure adequate sanitization of a multi-use glucometer (machine to monitor blood sugar levels) and the kit for holding the glucometer supplies and failed	F 520		

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F 520	Continued From page 100 to administer medications to 1 resident (#64) in a sanitary manner. Furthermore, the facility failed to maintain an ongoing infection control program, to monitor, track and trend infections in the SNF (skilled nursing facility) to identify, investigate, control and prevent infections within the SNF. On 5/22/14 at 4:23 PM, administrative licensed nursing staff U during interview related to QA, reported issues for further review come up through the departments, or any incident reported by staff, or any thing on-line reported. The QA director would direct that concern to the appropriate department. The facility failed to maintain an effective quality assurance committee to develop and implement appropriate plans of action to correct identified quality of care concerns for all residents of the facility.	F 520		